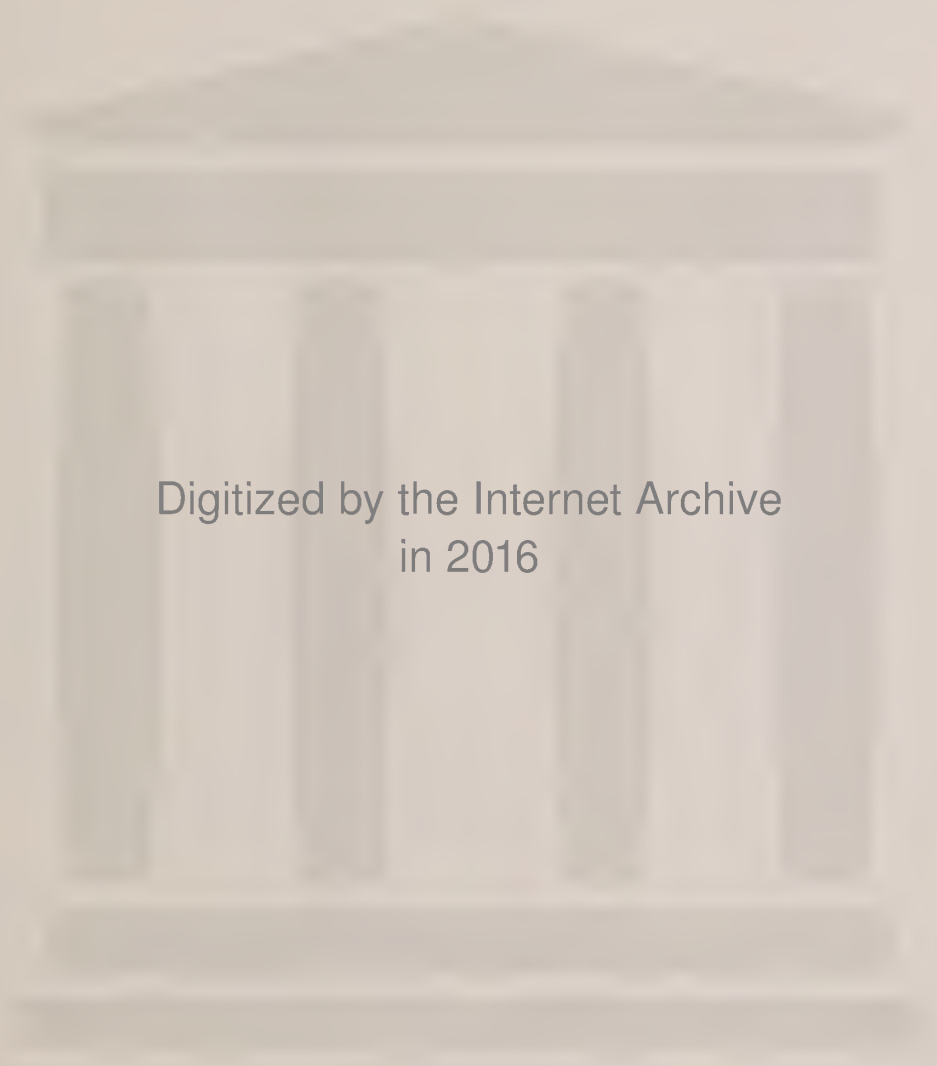
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THE JOURNAL
OF THE MEDICAL SOCIETY OF NEW JERSEY

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NEW YORK ACADEMY OF MEDICINE

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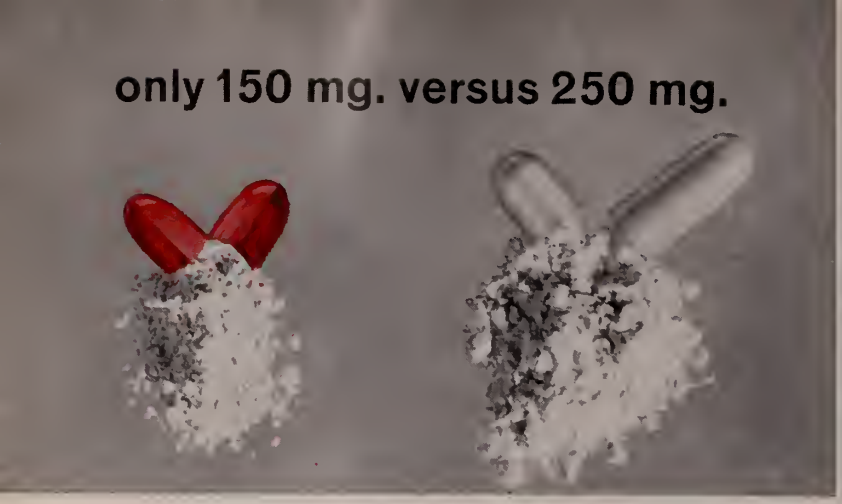
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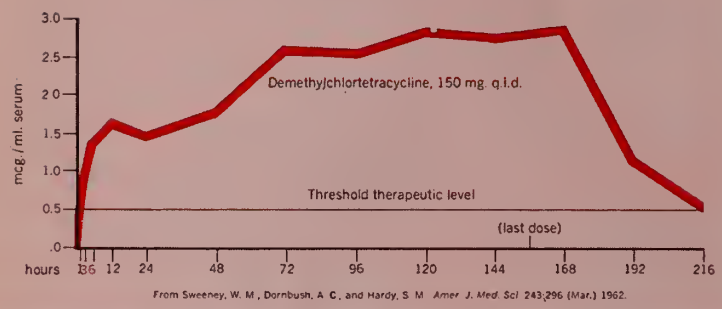
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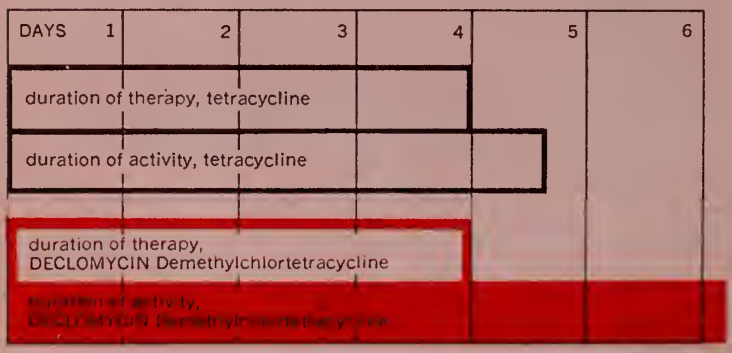


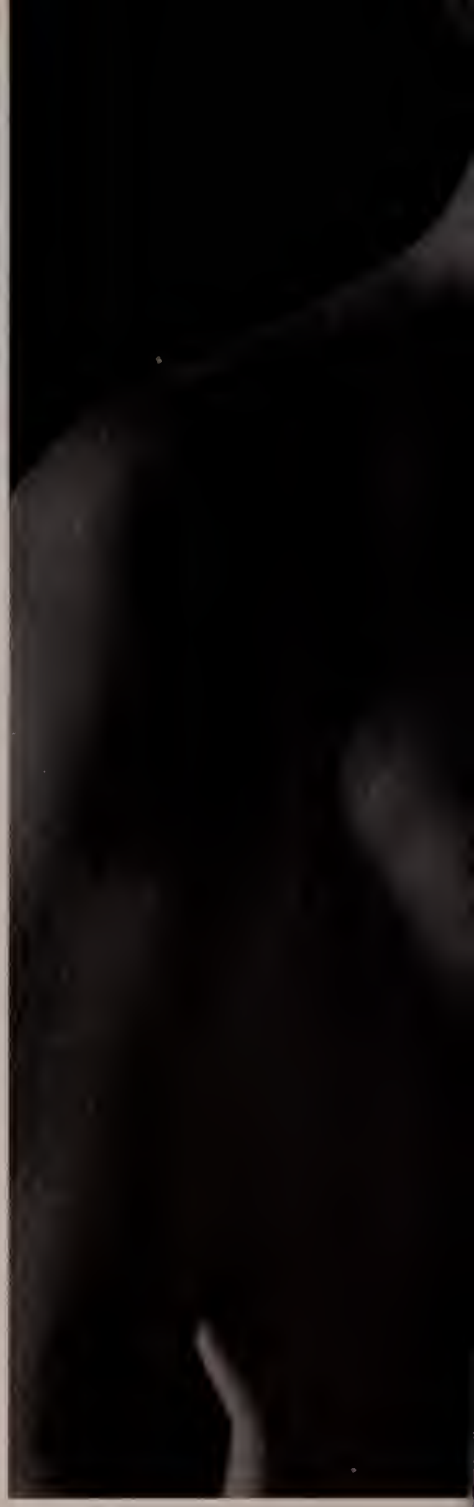
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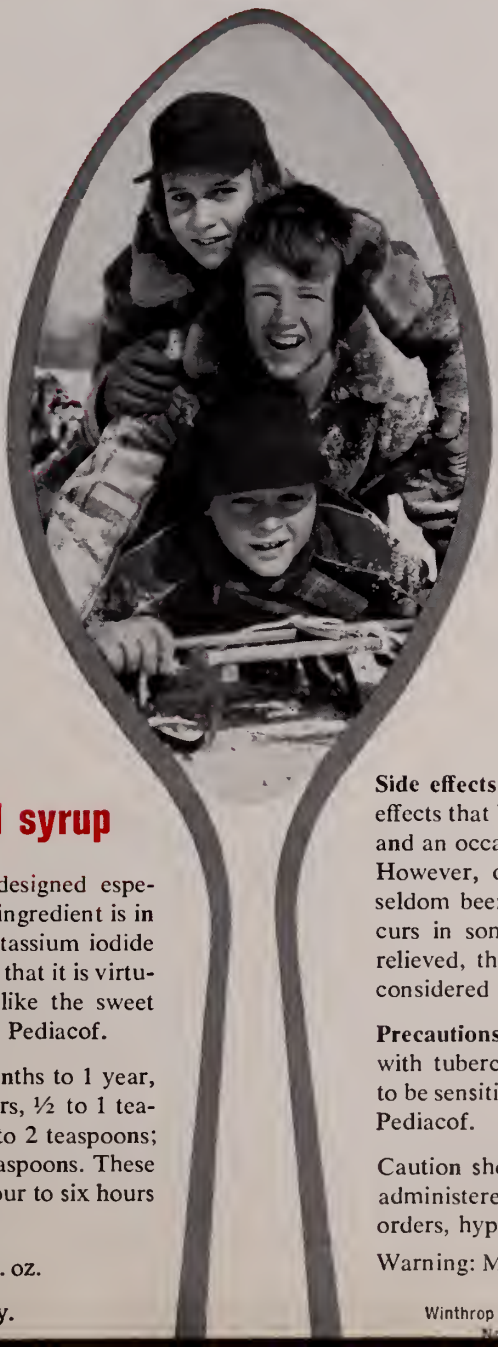

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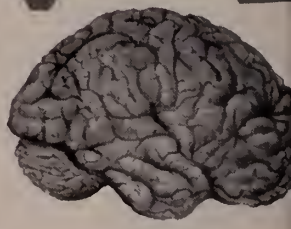
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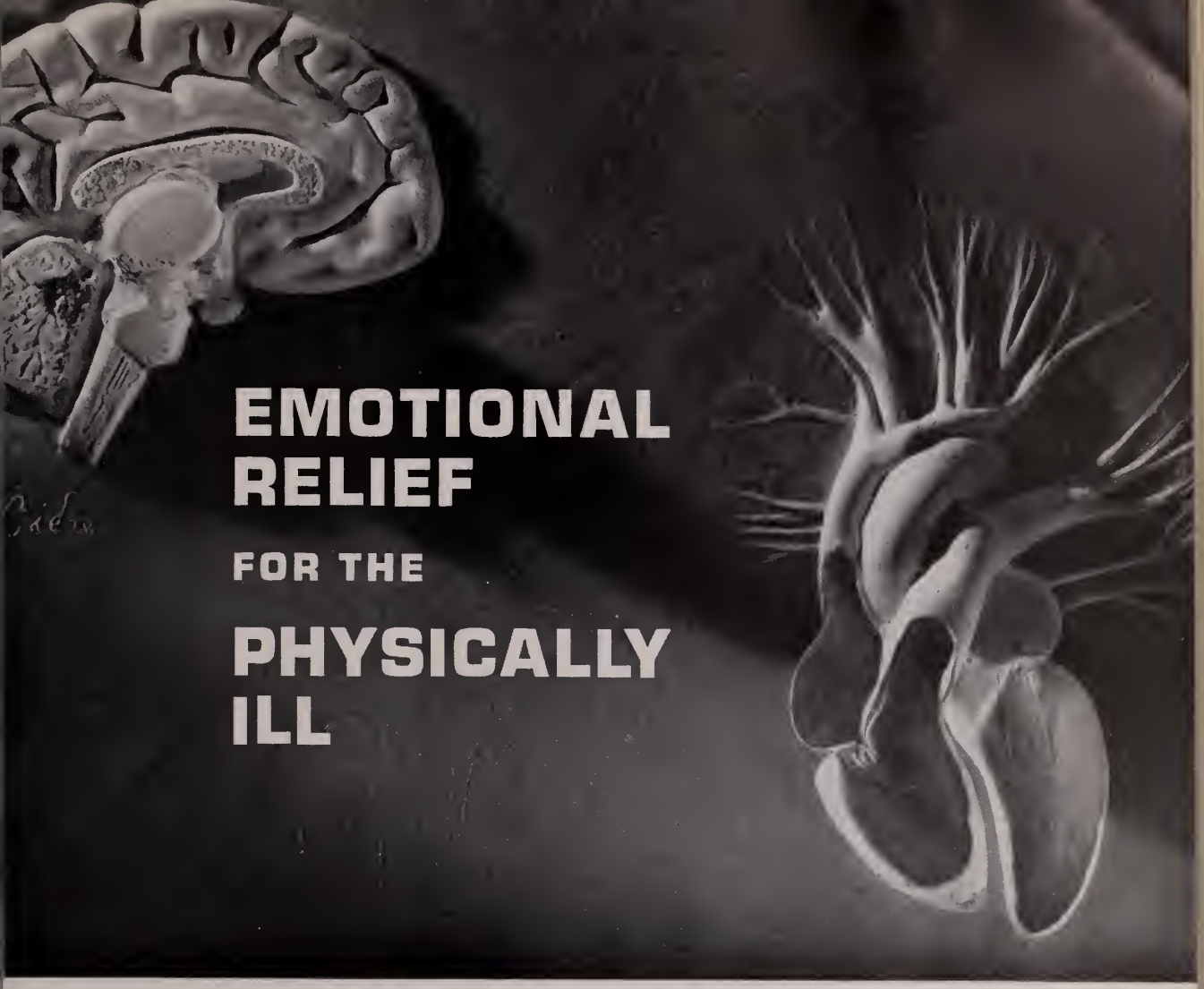
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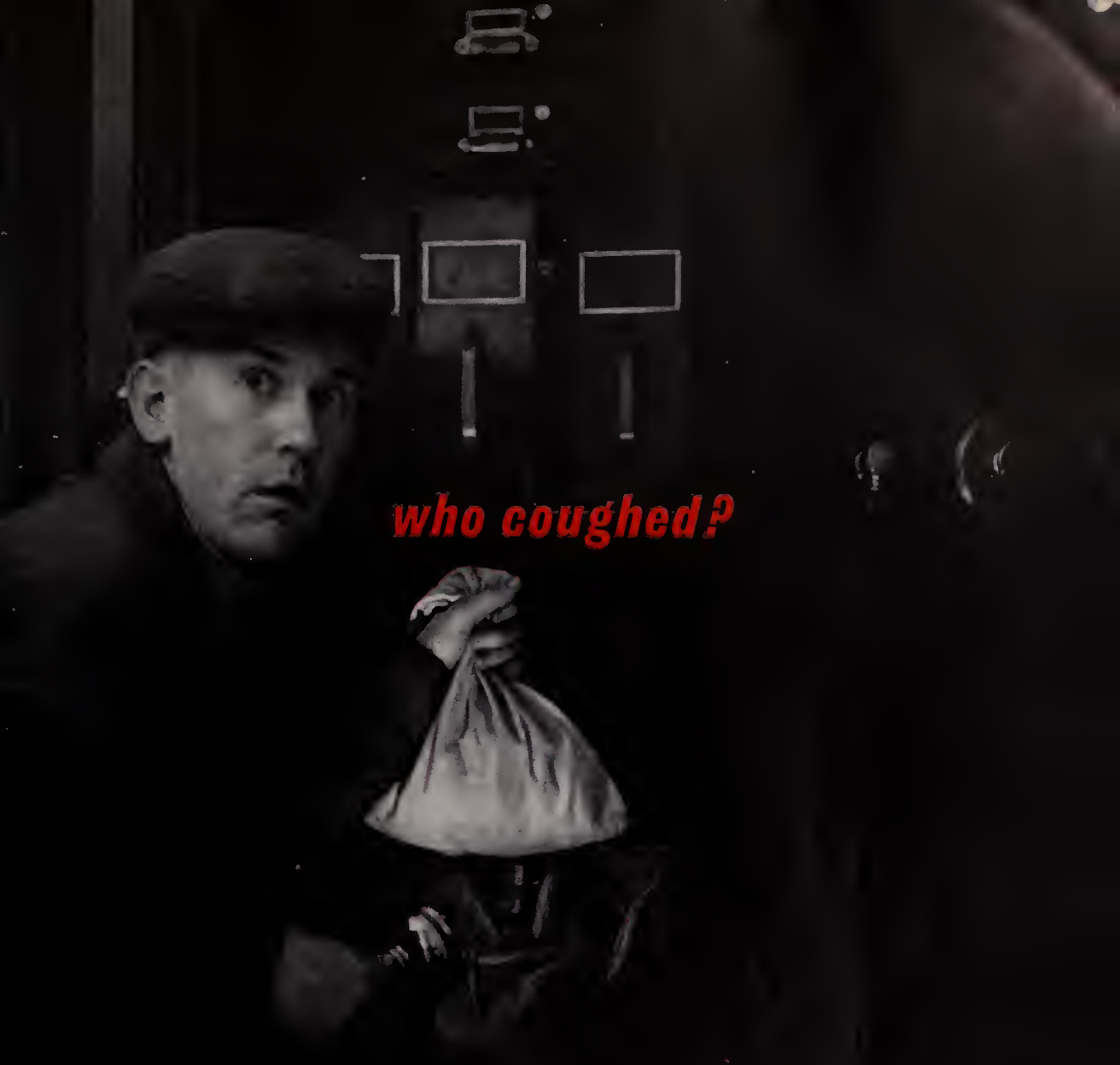
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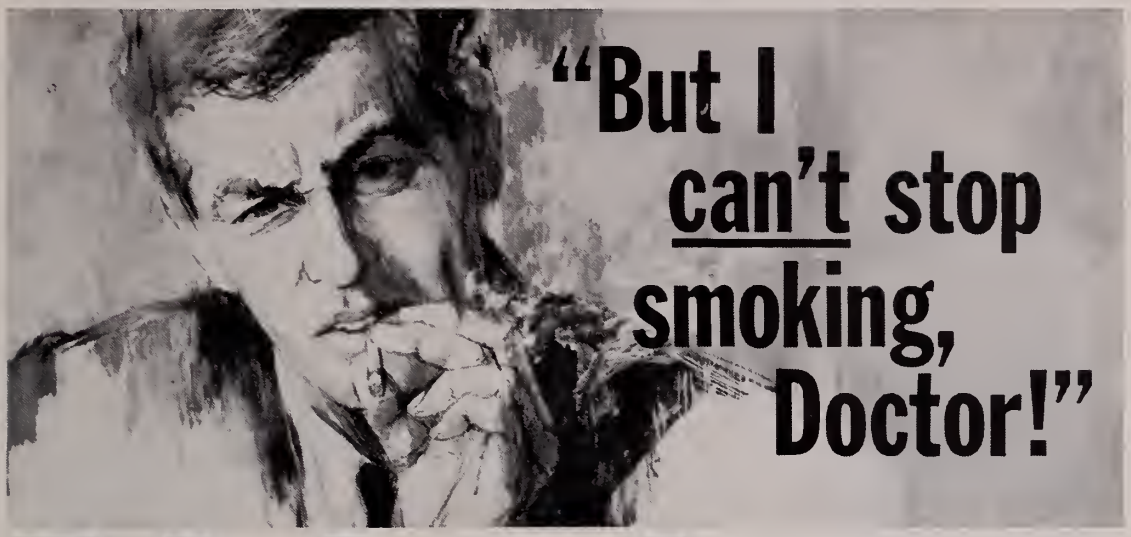
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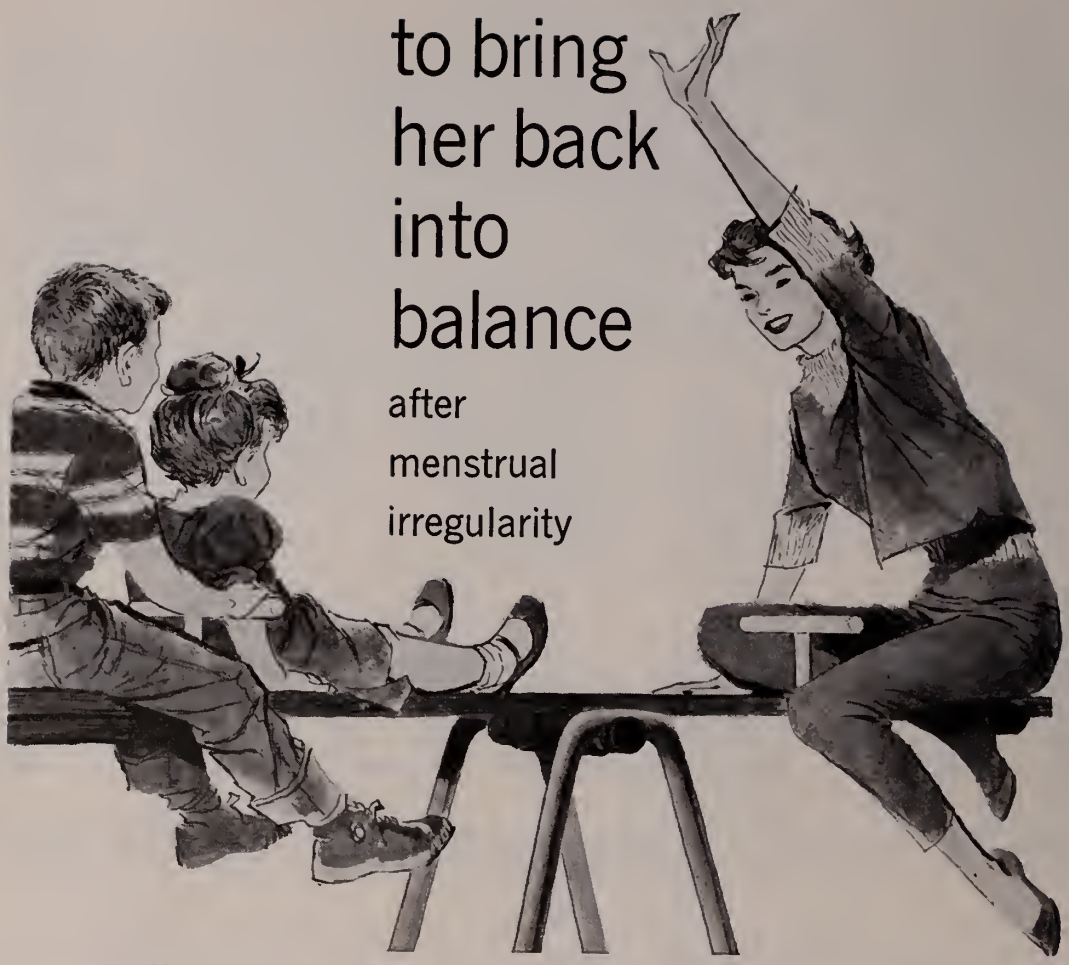
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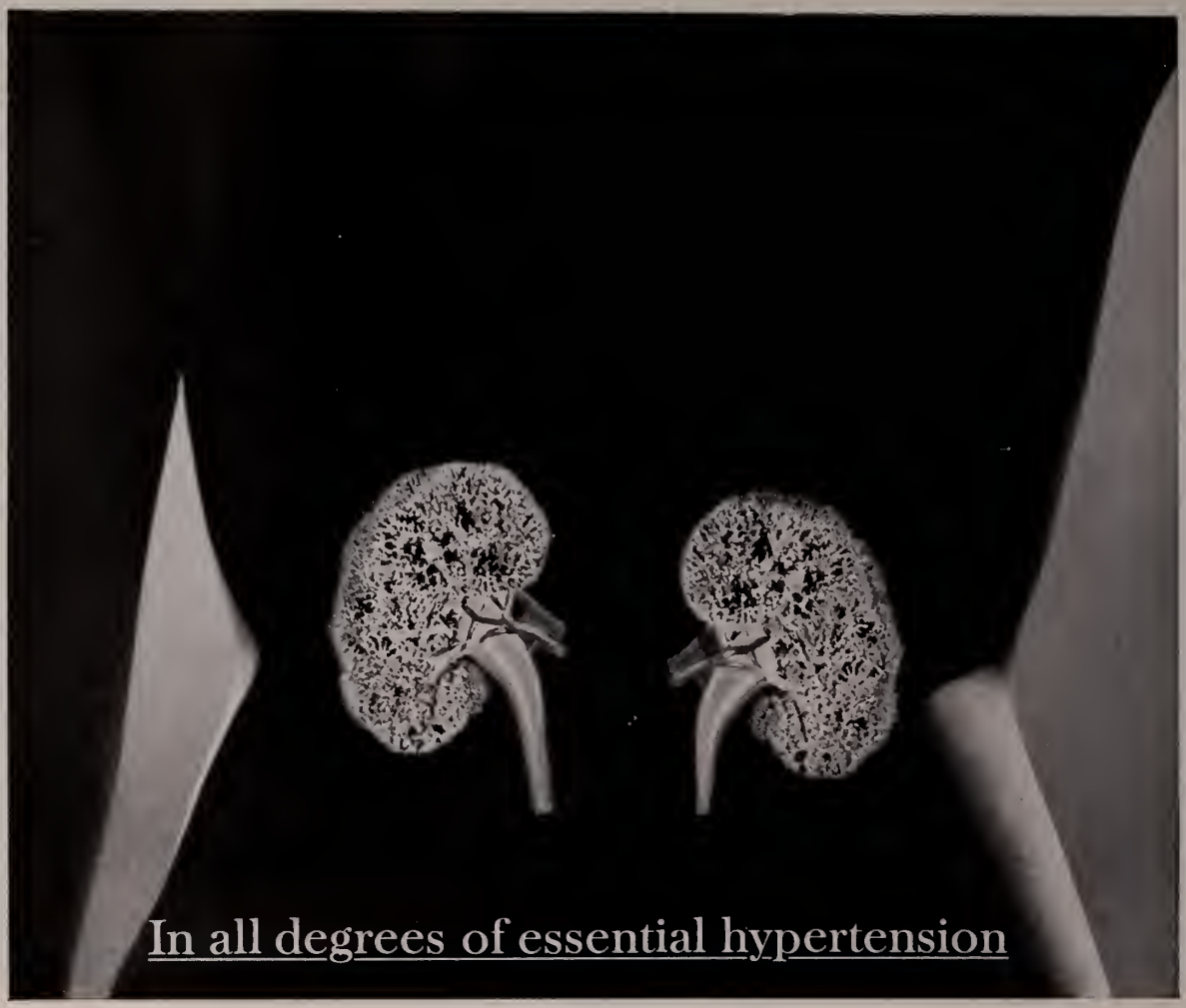
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References: (1) Moyer, J. H., and Heider, C.: Am. J. Cardiol. *9*:920 (June) 1962. (2) Brest, A. N., and Moyer, J. H.: Pennsylvania M. J. *63*:545 (Apr.) 1960. (3) Berry, R. L., and Bray, H. P.: J. Am. Geriatrics Soc. *10*:516 (June) 1962. (4) Hutchison, J. C.: Current Therap. Res. *4*:610 (Dec.) 1962. (5) Feldman, L. H.: North Carolina M. J.: *23*:248 (June) 1962.

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* AMA Council on Foods and Nutrition: The Regulation of Dietary Fat, *JAMA* 181:411-423 (August 4, 1962).
AMA Council on Foods and Nutrition: Composition of Certain Margarines, *JAMA* 179:719 (March 3, 1962).

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who were the untreatables"?

rom their inception with cortisone, to the present-ay variants of the steroid molecule, the corticoster-ids have presented a therapeutic paradox. The eneficial action against inflammation and allergy as ell as several undesirable metabolic effects are all, pparently, the results of the same basic physiologic tion.[1]

me of these associated metabolic reactions made it sky or otherwise undesirable to treat with steroids rge numbers of patients in various categories who ould otherwise have benefited from such manage-ent. These "untreatables" were overweight, had rdiac disease, hypertension, or pulmonary fibrosis sociated with congestive heart failure. Also in is category were those patients whose emotional mptoms were aggravated by earlier steroids.

ut the advent of ARISTOCORT® Triamcinolone in 58—the result of biochemical and pharmacologic search which successfully stripped away many nportant undesirable hormonal effects from the imary anti-inflammatory action—dramatically anged this picture. This steroid did not overstimu-te the appetite, or cause the excessive weight gain duced by other steroids;[2-7] it proved to have one of e best records of any steroid for *not* causing edema, salt-and-water retention;[2,3,7-10] and the incidence undesirable euphoria with this agent was remark-ly low.[2,4,5,9,10] What is most significant is that these nefits have stood the test of more than 5 years of idespread use. And, of course, the avoidance of ese distressing hormonal effects benefited *all* pa-ents requiring steroids, not just those in the special tegories, as demonstrated by wide clinical use.

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Contraindications. While the only absolute contraindications are tuberculosis and herpes simplex, there are some relative contraindications (peptic ulcer, glomerulonephritis, myasthenia gravis, osteoporosis, fresh intestinal anastomoses, diverticulitis, thrombophlebitis, psychic disturbance, pregnancy, infection) to weigh against expected benefits.

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EDITORIALS

Our New Journal

January 1964 heralds a new JOURNAL of the Medical Society of New Jersey. It is new from cover to cover—including the covers. The new layout and our new printer give us considerable flexibility, including color printing. It puts our JOURNAL in a class that is second to none in the nation. Its merit is here for you to see.

The production of a new JOURNAL has required a great deal of work on the part of many people. Their willingness to work and their diligence has been remarkable. The Board of Trustees, with their very able chairman, Dr. Samuel Lloyd, have been most helpful and determined to improve our publication. Our immediate past-president, Dr. Louis Wegryn; our president, Dr. Jerome Kaufman; our president-elect, Dr. Charles Calvin; our second vice-president. Dr. Joseph Jehl; our executive director, Mr. Richard Nevin; and Dr. Lloyd—all contributed their time and efforts at our meetings. The previous Publication Committee—headed by Dr. Frank Rosen of Maplewood—deserve our praise for their work in laying much of the ground work involved in the changeover. Dr. James Fitzpatrick of Trenton and Dr. C. Spencer Davison of Salem—members of the present Publication Committee—have been most helpful. Mr. Donald Tome of Hibbert Printing Company has been excellent as the liaison between us and the technical details of printing.

And we are, indeed, fortunate in having Dr. Henry Davidson as our editor. He is renowned and experienced; he is knowledgeable in matters editorial, medical, and organizational; and, in addition, he works!

Our assistant editor, Miss Theresa Goeke, a most capable person, *must* be credited with the bulk of the work which has been done to develop and expedite the new JOURNAL.

With the new JOURNAL, as with the old, we will remain dedicated to high standards. Our JOURNAL will continue to disseminate medical knowledge and other pertinent material to serve our needs. The technical details are changing, but the dedication to serve the common good remains ever the same.

GEORGE B. SHARBAUGH, M.D.
Chairman, Publication Committee

Our Silent Partners

Our advertisers are partners with you in the development of this JOURNAL. And they are partners, too, in the Annual Meeting. For one thing, the advertising fees and exhibit booth rentals provide much of the financial fuel that reduces the cost of both enterprises. We *could*, of course, hold Annual Meetings and put out a JOURNAL without the help of the advertisers. But this would not only skyrocket the costs—it would also deprive you of much of the color and instruction that characterize the JOURNAL and the meeting.

You can't just *buy* an advertisement here or rent exhibit space at the Annual Meeting. The Society has to be assured of the good faith and repute of the advertiser or exhibitor. We suggest, too, that our advertising pages are not simply bill-posters huckstering commercial products. They are, in truth, portable bulletin boards of what's new in medicine. New pharmaceuticals are the backbone of these advertisements. They tell you the generic name as

well as the trade-name. They give you indications and, just as important, contra-indications. They tell you how you can get more information about the product. No one derogates the value of your pharmacology textbooks. But like all medical books, they are almost obsolete before the ink is dry—so swift is the march of medicine. Our advertising pages also tell you about books, insurance offers, dietetic foods, local sanitaria and nursing homes, available office space, employment and partnership opportunities, automobile rental services, prosthetic appliances, and other interesting items.

We have compressed the advertising into the front and back sections of the JOURNAL. This may not be good practice from the viewpoint of the advertiser who would, no doubt, prefer to see his material next to reading matter. However, we do it to keep you from being heckled by distracting notices as you read. But if this has the effect of making you skip the advertising pages entirely, then we are not being completely fair with the advertisers. Fortunately, surveys indicate that most of our doctors do leaf through the advertising sections. We hope you all do. And when you send for samples or literature, please mention that you saw it in this JOURNAL. They really have no other way of knowing what impact they are making on you.

The partnership between American physicians and the American pharmaceutical industry has been a long and happy one. Our patients have been the chief beneficiaries. Advertising makes possible large sales; and large sales cause prices to come down. Were it not for advertising, many drugs would have to be priced beyond reach of our patients.

There is, of course, always the aloof critic who says he won't buy or prescribe highly advertised commercial products. For him, there is always available compound tincture of cardamom or nux vomica or Fowler's Solution or the other ancient stand-bys of the nineteenth century pharmacy . . . Quaint, colorful, noncommercial. But, alas!—ineffective, too.

So look through our advertising section—not as a tour through a commercial display, but as a swift graduate course telling you what's new in medicine.

Our New Printer

This issue is the first to be printed by Hibbert, our new printer. Here, we trust, is the beginning of a long and reciprocally advantageous relationship. While it has a sales office in New York City, Hibbert is a New Jersey organization with long roots in our state, and with five plants, all in New Jersey. It has been in continuous operation under the Hibbert name since the first presidential term of Grover Cleveland (also born in New Jersey, by the way). Hibbert has done work for more than two dozen nationally known organizations. We find ourselves in such company as Johns-Manville, Humble Oil, American Telephone and Telegraph, and American Cyanamid.

Hibbert has its own letterpress and offset plants, its own art department, and its own bindery. They even operate a publishing house. The station number in the center of your telephone dial was printed by Hibbert. This looks simple, but really it is a complicated bit of printing. In the last three years, Hibbert printed enough of these cards to reach from the pavement on Fifth Avenue to the top of the mast of the Empire State Building, if you should take the trouble of stacking them all up that way. Every telephone dial number card used in the U.S.A. or in American phones anywhere in the world was printed by Hibbert. They also have a king-sized unit for processing mail order operations.

The Garden State is, of course, famous for its thriving industrial and commercial enterprises. Hibbert is one of them, and we welcome them to our Medical Society team. We trust you will see the results in the fresher, cleaner, brighter, and sprightlier pages of this JOURNAL.

ORIGINAL ARTICLES

A far cry—or is it?—from the traditional, objectively scientific article is this inspiring and moving talk by Dr. Haun.

A Psychiatric Look At Bomb Shelters*

Paul Haun, M.D./Trenton

In frontier America a number of simple handicrafts were born out of the harsh demands of reality. Later, these came to be cherished, not because they were utilitarian but because they expressed in a direct and straightforward way the creative solution of an ingenious people to an eminently human problem. Among these handicrafts was the patchwork quilt. No thrifty housewife was without her box of pieces: snips of gingham from Aunt Abby's dress, a remnant from Priscilla's apron, a few inches of muslin saved from the yard goods for Isaac's Sunday shirt. From diverse materials, varied shapes, wide ranging colors, and a multitude of designs, there finally emerged a pattern: Joseph's Coat, Flower Garden, Log Cabin, Feathered Star.

I would like to stitch together a patchwork of disparate ideas, of historical fragments, topical concerns, and simple insights with the thread of speculation, in the hope that we may discern a pattern of affirmation and of hope through the shadows of anxiety which obscure our vision. The patchwork quilts my grandmother sewed were made of homely stuff, as every day as the thoughts I want to share with you, the skill of her calloused fingers no more refined than the unsophisticated logic which is the best I can hope to achieve.

Let me start with the Bible, Chapter 31 of the Book of Numbers.

"And Jehovah spake unto Moses, saying: 'Avenge the children of Israel of the Midianites; afterward shalt thou be gathered unto thy people' . . . . And they warred against Midian, as Jehovah commanded Moses; and they slew every male. And they slew the kings of Midian with the rest of their slain . . . . And the children of Israel took captive the women of Midian and their little ones; and all their cattle, and all their flocks, and all their goods, they took for a prey. And all their cities in the places wherein they dwelt, and all their encampments, they burnt with fire . . . . And they brought the captives, and the prey, and the spoil, unto Moses, . . . unto the camp at the plains of Moab . . . And Moses was wroth with the officers of the host, the captains of thousands and the captains of hundreds, who came from the service of the war. And Moses said unto them, Have ye saved all the women alive? Behold, these caused the children of Israel . . . to commit trespass against Jehovah . . . Now therefore kill every male among the little ones, and kill every woman that hath known man by lying with him. But all the women-children, that have not known man by lying with him, keep alive for yourselves."

Fire - - - fire and the sword. Man is neither stranger to death nor unacquainted with sorrow.

In Pelusium in Egypt in the year 542 a man died of the plague of Justinian. Within a few months the pestilence had reached Constantinople but here 10,000 people died in a single day. It struck Italy in 543 and in the following

*Dr. Haun is Director of Psychiatric Education for our State Department of Institutions and Agencies. This paper was read May 15, 1962 at the Annual Meeting of The Medical Society of New Jersey.

three years nearly depopulated the country, leaving it an easy prey to the Lombard invaders.

In the fourteenth century occurred the seemingly endless cycles of the Black Death destroying 13 million people in China before spreading to Armenia, North Africa, Sicily, Constantinople, Greece, Spain, Italy, Eastern Germany, France, the British Isles, and Scandanavia. Nearly three quarters of the population in various sections of Europe died in the first wave. Hecker calculates that 25 million individuals, or one quarter of the entire population of Europe, died in the successive series of epidemics.

In 1665 the Great Plague struck London; 43 died in May; 590 in June; 6,137 in July; 17,036 in August; 31,159 in September, out of a residual population of 153,000, twice as many people having already fled to avoid the pestilence.

In 1899 the mortality from plague in Hong Kong was 95 per cent! In 1905, one year before I was born, there were 940,821 cases in India.

But enough of Timurlane's mountain of skulls; of Pompeii destroyed in a single breath; of man's savagery to man and of natural holocausts wiping away a civilization. The Midianite father did not watch the sword passing through the body of his wife. He didn't have to. He was already dead. The Midianite mother was spared, but only long enough before her own destruction, to see her four-year-old son decapitated and to learn that her nubile daughter would lie that night on a pile of sheepskins with his slayer.

The Impolite Reality

Is a mushroom cloud more menacing than a plague-stricken London dwelling with the scarlet cross and the legend "God Have Mercy On Us" painted on the door? Is the ticking of a Geiger counter more terrifying than the vigil of those who watch a child die of plague, with the certain knowledge that no one can ever leave the house since the shutters and the doors have been nailed shut by neighbors who also fear the pestilence?

Death is an impolite reality, and I apologize for the bad taste of pointing to its imminence; yet it is with death that all of us are to be involved; for some tonight, for others somewhat later on. Death will surely visit us and every man, whether the missiles are across the seas or rust forever in their silos. Is it the threat of personal destruction that alarms us when we learn of atoms wrenched apart? Then we are afraid of life itself for death has always been its companion. Is our concern the number of the slain when we hear in our imagination the crashing thunder of the megatons? Then we share the same sense of doom felt ages since in Midian. Is it the end of beauty, of music, of art, which we cannot face? What less did Pompeii lose to the ashes and the lava of Vesuvius?

Perhaps you will say: "Yes, I know all this. For me death is only death however it arrives, however many it destroys, whenever it comes. When I die the only world that I can know dies with me." But then you add: "It really is the children. Are they not truly the future? Mine and all mankind's? I don't really matter but they most assuredly do."

For ages man has speculated on the essential difference which distinguishes him from other forms of life. He is the only animal who consistently uses tools. His is the largest neopallium proportionate to the size of his brain. He alone has been freed from the tyranny of instinct. True as these and a score of other physiologic characteristics may be, they leave us with much that clearly separates our species from tree frogs, from cattle, and from Moray eels but with little which defines the essentially and the uniquely human. For me, man's truest quality is formed of two complementary and inextricable parts: the foreknowledge of his own death and his ability to believe with the tremendous force of his entire being in something greater than himself - - - in an ideal.

Let me stitch another bit of patchwork to our pattern.

"And it came to pass after these things, that God did prove Abraham, and said unto him, 'Abraham'; and he said, 'Here am I'. And he said, 'Take now thy son, whom thou lovest, even Isaac, and get thee into the land of Moriah; and offer him there for a burnt-offering upon one of the mountains which I will tell thee of'. And Abraham rose early in the morning . . . and took . . . Isaac his son; and he clave the wood

for the burnt-offering, and rose up, and went unto the place of which God had told him. On the third day Abraham lifted up his eyes, and saw the place afar off. . . . And Abraham took the wood of the burnt-offering, and laid it upon Isaac his son; and he took in his hand the fire and the knife; and they went both of them together. . . . And they came to the place which God had told him of; and Abraham built the altar there, and laid the wood in order, and bound Isaac his son, and laid him on the altar, upon the wood. And Abraham stretched forth his hand, and took the knife to slay his son. And the angel of Jehovah called unto him out of heaven, and said 'Abraham, Abraham': and he said, 'Here am I'. And he said, 'Lay not thy hand upon the lad, neither do thou any thing unto him; for now I know that thou fearest God, seeing thou hast not withheld thy son, thine only son, from me.' "

Humanity's truest heroes have been those who have most clearly asserted their humanity, without reserve, without equivocation. The essential mark of that humanity is an unshakeable conviction in the supreme importance of the ideal. Socrates refused the tearful pleading of his friends who would easily have arranged his escape and chose rather to drink the hemlock. He threw his life away like a worn sandal in the service of an ideal which, by his very act, was given immortality.

In the naked account of Abraham's willingness to sacrifice what was to him of infinitely greater value than his own life because, and only because he had heard the voice of God, we see in stark and perfect form the absolute distinction between man and beast, the ultimate transcendence of the ideal.

Fourteen years ago I reviewed the detailed architectural plans for a prototype 500-bed hospital proposed as medicine's answer to atomic war. It was windowless and partly under ground. Its walls, many feet in thickness, were to be of heavily reinforced concrete. A vast space in a doubly fortified central bastion was designed for the evacuation of those patients on each floor who remained alive after the initial blast. There was an empty cavern far below to which they were to be carried if the central fort was itself destroyed. The proponents had not detailed how the occupants of the structure were to be fed; how light was to be provided; what disposition was to be made of wastes, human and otherwise; where a reliable source of uncontaminated water was to be sought; or how the air one breathed was to be filtered. A more serious omission was the lack of any recommendation as to where these extraordinary buildings were to be constructed. Of course any suggestion of this nature would have presupposed knowledge of the areas most likely to be attacked and a naive belief in the infallible accuracy of the enemy's guidance systems.

It is almost needless to say that the structure was never built. It *is* needless to say that certain of the simpler omissions in design have been corrected by subsequent generations of planners. I would stress, however, that these *are* the simpler, not the major omissions.

If for a moment we were to accept the hypothesis that even a minimal amount of protoplasmic survival following an atomic holocaust was the one goal toward which all our efforts should be directed, the inevitable question follows: "Where do we stop?" Surely not with windowless, lead encased hospitals, or with so-called shelters. Certainly a priority case must be made for a potentially impervious system of communications, for sheltered breeding stock and seed grains, for human semen banks, for multiple microfilming of patent office files, and the contents of the Library of Congress.

Can we end here or must the mint go under ground? What of mortgages, bonds, debentures, and bank records to guard the post-war world from anarchy? Must not our utility plants be duplicated in some limestone cave, our essential machine tools secured, and at least a few Bessemer converters and high vacuum furnaces protected against all contingencies?

I am laboring the point to support the suggestion that there is no place at which we can reasonably draw a line. If we choose the way of the troglodyte I see no turning in the road, no pathway back to our fields and the sun. I would further suggest that major atomic war *in the event* has every quality of those catastrophies which once were called, with resignation, acts of God. In terms of the lives which we hold dear, in terms of that form of civilization which is the best we have experienced and so is the form we most deeply cherish, in terms of our liberal concern for all humanity, such a cataclysm *in the event* would differ in no significant way from an inter-planetary collision.

I have twice said *"in the event"* and this is my careful qualification. Should the earth catapult into the red canals of Mars, it would indeed be an act of God and there would be no hiding place. If, not when, but if major atomic war occurs, I hold there will be no material safeguard worth a second's rational thought. But it is not the realistic futility of a structural defense that I would stitch into my pattern, it is rather the offense against our humanity, the conscious choice of the way of the beast when the path of the man is clear before us.

A Psychiatrist's View

Let me speak now as a psychiatrist. The phobic patient who fears contamination seems at first to be eminently rational. Since he is surrounded with pathogenic micro-organisms, any variety of which can cause him to sicken and die, what more sensible than prophylaxis? He washes his hands more and more frequently. Soon scrubbing with germicidal soap commends itself as a more reliable safeguard. But then the towel on which he dries, how clean is it? Certainly it must be used only once. Wouldn't home scouring be safer than to have his linens swirled about at a commercial laundry in all the muck from countless scabrous bodies?

For a time impervious gloves seem to be the answer until he is sickened with the realization that food also is filthy with the off-scourings of unclean humanity, the offal of animals, and the vomitus of flies. How endless are the cycles of reinfection from his every body orifice?

He cannot meet his fellows. He cannot leave his house. Opening the door of his room sends him into panic. More and more hopeless effort is drained away in a combat which increasingly grows so complex that time itself runs out. Only ritual remains and only magic can be opposed to a universe of menace.

The phobic patient exists. I have seen him. My colleagues have seen him. Am I too bold to assert that a society also may become phobic, to hint that there is a psychic infectivity in mass example, to suggest that the proposed flight into an ever mounting spiral of materialistic safeguards has for me, at least, a sickening counterpart in individual psychopathology?

Again, it is not the realistic futility of the phobic patient, scrubbing and scouring, that saddens me, nor the ineffectiveness of his pathetic efforts at universal asepsis. When I speak not as a physician (whose dynamic concern is with the wellsprings of causation) but once again as a layman, my distress is rather with the phobic's offense against his own humanity, his choice of the materialistic answer, of the immediate, of the niggling; in short, with his preference for protoplasmic survival, at the expense of his humanity, and the suprapersonal ideal.

"But," the pragmatist will say, "you overstate the case. What is incompatible between a bomb shelter and the preservation of an ideal? You say, 'Let Spinoza and Confucius and Kant be killed at the age of ten rather than spend two weeks in a lead-lined cave'."

Yes, that is precisely what I say, because they became Spinoza and Confucius and Kant only by reason of their struggle toward the truly human state; because they were more than surviving aggregates of protoplasm. I am compelled to say it because I believe that a journey of 10,000 miles begins with a step; because I remember the initial rational assumption of my phobic patient and his sorry end; because Abraham's reply to God was "Here am I"; because St. Joan would make no deals with Warwick, although she knew the alternative was the stake; because I have heard with disbelief Bertrand Russell say "Better Red than dead," and have listened to a still small voice within me say "No, better man than beast."

Reduced to their essentials, what do our lives import? We are born, we reproduce (a few of the fortunate among us love), and we die. Santayana, that wise old man, instructs us that "There is no cure for birth and death save to enjoy the interval." He was not being flippant, for how *are* we to "enjoy the interval" save with Paul Tillich's "Courage to Be?" The ground of such "Being" is belief. For the citizen of classic Athens it was belief in virtue, for the Roman in courage, for the Hindu mystic in cosmic unity, for St. Joan in France, for Albert Schweitzer in respect for life and for the physician in a compassionate dedication to all who suffer. The ideal is always bigger than ourselves. It is always worth the ultimate sacrifice.

America has repeatedly shown an abiding and unshaken faith. Not a few of our forebears and of our associates have given primacy to their beliefs, now in war, and now with equal or greater significance in peace. There have been men who stood without reserve for integrity and truth, for liberty and freedom, for tolerance and for understanding. There are such men today.

It is our human task to save our children and ourselves, our civilization, and mankind from a catastrophe. How shall this be done? It is our hope and our affirmation that it can and will be done. We have a thousand choices, from an unequivocal policy of non-violence at one extreme to the doctrine of limited war at the other. The task is clear. The instrument is our determination. Only the means remain to be debated. We cannot afford to burrow underground, to hide the seriousness of our need with busy work. Most of all, we cannot brazenly ignore our human destiny and start the journey back to Proconsul and the simian night. Man does not barter his humanity for the biologic survival of his protoplasm.

In Conclusion

My patchwork pattern is complete, and it is this:

1. Death and life are opposite sides of the same coin. When we say "Yes" to one we inevitably affirm the other. The attempted avoidance of death regardless of the human costs at once takes us into the unreal land of fantasy and the meaningless rituals of magic.

2. Man is less than human when he denies his true nature, when his cardinal goal is materialistic, when he willingly exchanges belief in a supra-personal ideal for the animal trance of biologic survival and the pottage of protoplasmic security.

3. A genuine holocaust *in the event* is simply death with a fancy name. It must be met with the same personal courage, the same resignation with which as individuals we face the termination of our several lives.

4. If we elect to live during the span each of us may have, if we choose to preserve our world, the future of our culture and the heritage of our children, then our common effort will be wisely directed toward the certain arrest of global catastrophe, toward the prevention of the holocaust, toward the erection of an impregnable barrier to atomic war.

135 West Hanover Street

Eye Screening Program

A comparison of our Society's 1962 and 1963 screening programs shows an increase in overall activity and a decrease in positive findings.

Number		Change Over 1962 More	Less
68	Participating centers	4½%	—
8157	Individuals screened	5 %	—
4402	Negative results	4 %	—
3755	Positive results	—	4 %
462	Tonometry positive	—	1 %
3188	Visual acuity positive	—	5 %
382	Positive external inspection	—	1 %
851	Ophthalmoscopy positive	—	1 %

Smoking Booklet Available

From the American Cancer Society at 621 Central Avenue, Newark, any member of The Medical Society of New Jersey can obtain a booklet summarizing the evidence upon which the American Cancer Society bases its position that cigarette smoking is the major cause of the unprecedented increase in lung cancer.

Of particular interest is a section on "Dissenting Opinions". This provides answers to those who question the evidence.

The regime here outlined can take much of the fear out of operating on elderly cardiacs.

An Anesthesiologist Looks At The Elderly Cardiac*

I. M. Riffin, M.D./Upper Montclair

The skillful anesthesiologist does not face with trepidation the well-compensated elderly cardiac. An accurate appraisal of functional capacity is the anesthesiologist's primary function on pre-operative rounds. A recent coronary occlusion (within 3 months), angina pectoris, and frank congestive heart failure are, however, serious factors in increasing operative mortality.

The borderline, "occult" cardiac, (the person who gives a history of dyspnea with exertion of minimal extent or mild ankle edema at the end of the day) is benefitted by one or two cubic centimeters of mercuhydrin the night before the operation. By removing excess fluid from the lungs, diffusion of oxygen, carbon dioxide, and anesthetic gases are improved.

An appraisal of blood volume, especially in cancer patients, is vital. The hematocrit gives a fairly good estimate of blood volume. As a rule of thumb, 35 per cent should be the minimum. However, the more accurate determination of blood volume by means of radio-isotope dilutional technics is mandatory in some and advisable in other patients prior to the stress of surgery and depressant anesthetics.

A practice which I follow, and will probably be subject to wide divergence of opinion, is to minimize the pre-operative sedation in the late 60's and give none at all to those 70 and over. Intra-operative hypotension associated with precedent anti-hypertensive or cortisone therapy is not frequent unless the patient is taking large doses. I have never felt it necessary to cancel a case, although I do give cortisone the night before and the morning of the operation.

Administration of Anesthesia

Regional technics are preferable. In vaginal procedures (including vaginal hysterectomy) caudal anesthesia is eminently successful and is associated with the least physiologic derangement. Spinals and epidurals are also valuable. However, the sympathetic blockade which accounts for 90 per cent of the physiologic effects of this technic may be quite diffuse, i.e., out of proportion to the sensory level obtained.

General anesthesia in competent hands should not increase operative mortality or morbidity. The basic tenets in the conduct of a general anesthetic are a smooth induction with minimal anesthetic dosage (i.e. practically analgesic levels) and adequate ventilation to forestall the possibility of hypercarbia. An adequate estimation of blood loss is both the surgeon's and anesthesiologist's primary concern because shock, in the arteriosclerotic cardiac, is frought with the danger of coronary occlusion.

In the elderly cardiac, when fluids are given intravenously, I believe that close observation of the dilatation of the neck veins, i.e. jugular, especially when filling from below occurs, is an excellent sign of impending congestive failure. The determination of venous pressure with a 3-way stopcock, intravenous tubing taped to the standard, 5 cubic centimeter sodium citrate, and

*Read by invitation on May 13, 1963 Annual Meeting of The Medical Society of New Jersey.

a ruler is simple, effective and valuable. The intra-operative therapy for rising venous pressure and impending congestive failure is intravenous 1.0 milligrams digoxin or 1.6 milligrams deslanoside and, of course, minimizing the administration of intravenous fluids.

Post-Operative Period

The post-operative period in the recovery room is a continuation of the anesthetic. After a prolonged general anesthetic and following the use of muscle relaxants, more frequent use of the mechanical respiratory assistors is indicated. An electrocardiogram should be routine if the blood pressure goes below 90 or if the pulse is above 120; or if the recovery room nurse finds any irregularity of the pulse.

Summary

With adequate pre-operative evaluation and preparation, with careful attention to details of good anesthetic practice intra-operatively, and with meticulous post-operative care, the elderly cardiac can go through all gynecologic surgical procedures without a distinct increase in morbidity and mortality.

419 Park Street

Chaos in Drug Research

Drug research is replete with examples of dismay and changed plans for drug producer and researcher. Ten U. S. pharmaceutical firms so far report curtailment of research and development. One company claims that of 67 agents "out" for clinical trial as of July 1962, thirteen were discontinued on August 10 (the date the new investigational drug regulations were officially proposed), 37 more were discontinued from clinical evaluation by June 7 (when full compliance with the new regulations was required), and only 17 are being continued. Another firm acknowledges that 90 investigations under way in August 1962 have been discontinued, 20 of which were almost complete. Still another company has dropped 30 per cent of its projects though all were rated "good" to "enthusiastic" by research personnel. Other firms report a cutback in a number of projects despite increased research and development expenditures. Two midwestern companies closed their research departments. Others are considering the initiation of more research abroad or are viewing with interest the possibility of mergers with stronger firms.—Austin Smith, M.D., President, Pharmaceutical Manufacturers Association, to Federal Bar Association, June 27, 1963.

One Industry That Stands By Its Products

The drug industry is facing a critical period concerning research for new drugs. The physician should have available modern discoveries even though there may be side effects in some of them. The drug industry knows then they have discovered something beneficial for mankind. The thinking citizen of this country should not condone the "whipping-boy attitude." Politicians prey on people for votes. The pharmaceutical industry must stand on the merits of the products produced. Their voice should be strong and backed by other professions in the medical world to insure our medical progress—George X. Schwemlein, M.D., in *Cincinnati Journal of Medicine,* August 1963.

This is the first of a series of articles on the commonest presenting symptom in medical practice.

Pain I*: What is it?

Fred A. Mettler, M.D./New York

A comprehensive view of pain is difficult to acquire and even more difficult to present. There are two reasons for this difficulty: (1) when we speak of pain we do not always refer to the same experience; and (2) pain, being everyone's business, ends up by being no one's responsibility.

Definition

Pain cannot be satisfactorily defined in other than subjective terms. Its objective concomitants are so inconsistent that in the last analysis we are always forced back to George Bishop's definition[1] that "Pain is what the subject says hurts." Obviously the subject may be lying but, with the exception of children (sociologically as well as chronologically speaking), it is surprising how few persons complain of pain who are not, in fact, miserable. (Concerning the nature of this misery more is said below.) Furthermore, if the physician is not willing to transmit by record what the patient says, he is inviting a rupture of the patient-physician relationship and a possible lawsuit. It may be an injustice to someone else to fail to credit the existence of pain; but it is only a personal weakness to allow oneself to be imposed upon.

Variation in the objective accompaniments of indubitable pain reflects different subjective states. Objective phenomena vary depending upon whether the pain is a new, acute experience, or a chronic one; and upon the circumstances under which the pain occurs. We have all, after a period of great preoccupation and physical and emotional stress, been surprised to find we have received injuries we did not know we had—injuries which under other circumstances would have immediately elicited pain. To say that we have been "distracted" is less informative than the realization that pain is most disturbing when it is recognized as representing something which is a threat to the plans the individual has for his *self*.

In general, the objective accompaniments of sudden, severe pain, occurring under conditions which allow its recognition, appear as pronounced motor discharges such as reflex withdrawal, the emission of protracted, wavering vowel sounds, great restlessness, cardiac acceleration, and pupillary dilatation. There are, however, great differences. If the individual is expecting an injury, no sound or movement may occur. The same is true if fear takes precedence over pain. In cases of great environmental disorder (such as ship sinkings, volcanic eruptions, explosions, conflagrations and raking gunfire) the reaction of the individual may be that of complex disorientation[2] like the dangerously disorganized behavior of horses caught in a burning barn. A contrasting picture is presented by the immobile patient who has long been in pain. Such a person exhibits weakness, a loss of weight, and a chronically ill appearance. Freedom of both movement and intellect are suppressed; but beneath the rigidity of mind and muscle moves a choppy, restless sea of crabbed irritation. "I am", says Alice James (the sister of Henry), in the last entry in her *Journal*, two days before she died, "being ground slowly on the grim grindstone of physical pain, and on two nights I had almost asked

*Based on "Neurophysiology of Pain", a staff conference address, March 28, 1963, Department of Anesthesiology, Columbia University, College of Physicians and Surgeons.

for K's lethal dose; but one steps hesitatingly along such unaccustomed ways, and endures from second to second." Chronic pain impoverishes man by forcing preoccupation with its insistent problems. "The struggle against pain is usurious", says Leriche[3].

Acute and Chronic Pain

The difference between acute and chronic pain has its corollary in differences in the methods of treatment. The anesthetist and surgeon are more concerned with the acute, and the psychiatrist with the chronic. Sensations evoked by noxious stimuli newly applied to normal individuals are not always the same. One very obvious distinction exists between a particular variety of well-localized pain, which was formerly called epicritic (Head), pricking (Pieron), or sharp (Buytendijk) pain; and that previously spoken of as protopathic (Head) or "genuine" (Buytendijk) pain which is poorly localized.

Transmission of Pain

There has been a tendency on the part of recent experimentalists who have followed Zotterman[4] to identify pricking pain with conduction over the fast (20 to 40 meter per second) or delta fibers (6 to 3 micra in diameter) in the A component of mixed nerves; and to attribute "genuine" pain to conduction by the slow (1 or 2 meters per second), or C-fiber (2 micra or less in diameter) component of mixed nerve. This correlation depends upon the fact that (in experimental work) trained observers may be able to distinguish two responses to a single pricking stimulus. These are separated by a very brief interval which has been explained upon the basis of the lag in conduction between the C component and delta fibers. In other words, the double response is said to be due to the fact that the fast-conducting fibers relay their message to the brain appreciably ahead of the C-fiber message, which arrives in consciousness after the A-fiber message has subsided. An alternative explanation is possible. There is a strong body of opinion (stemming from the time of Max von Frey) who felt that the sensation of pain was due to the liberation of a chemical substance. It might be postulated that the delay of second pain is due to the fact that tissue damage is a necessary intermediary step. Opposed to both of these explanations are the observations of Woollard, Weddell, and Harpman[5] which have been verified by Margaret Jones[6]. Woollard, Weddell, and Harpman[5] found that the initial pain sensation is correlated with penetration of the epidermis and second pain with invasion of the dermis. Jones[6] similarly finds that double sensations are correlated with stimulation of more than one sensory field, whether on the same or different levels. If second pain were due to conduction by fibers of a different diameter, one might expect some difference in the quality of first and second pain sensations, such as exists between pricking pain and "genuine" pain; but not all observers have been able to distinguish any subjective difference between the two. The evidence that second pain, as encountered in experimental studies, is due to C-fiber conduction is, therefore, not compelling. Neither is it certain that these two experimentally detectable sensations are identical with pricking pain and "genuine" pain. There is, however, some reason to believe that the former is due to the fast-conducting delta fibers and the latter to conduction over C-fibers. Thus it has been observed by Pattle and Weddell[7] that it requires a considerably greater quantum of electrical current to provoke, from an exposed skin nerve, a long-lasting, severe, aching pain as contrasted with a wasp-sting-like pain which can be elicited by slight stimuli. (The threshold for C-fiber activation is approximately five times that for the delta-epsilon component of the A-fiber group[8].) It seems reasonable to believe that the "clear, short-lived, well-localized impression; . . . related to touch impression"[9], which can be produced by a pin prick, is most particularly carried over fibers 3 to 6 micra in diameter, whereas the "continuous, dull, penetrating pain—which is hard to locate and tends to spread beyond the point of stimulation" and "is not limited in time; . . . increases and decreases and alters according to external and internal circumstances", and which can be produced by applying strong pressure to both sides of a broad skin fold, is predominantly carried by fibers of 2 micra (or less) in diameter. "Genuine" skin

pain is closely related to the sensation of burning; and that of burning to itch. Almost all recent experimental work on pain sensation has utilized either a pricking or thermal stimulus. This leaves unexplored many insistent clinical problems, which apparently involve C-fiber activity. It is important for the general practitioner to recognize that, while a great deal of information has been accumulated about pain, the problems with which he has to deal have not exactly been flooded with light as a result of the current state of illumination.

This much is clear: it is not justifiable to neglect the patient's own estimate of his pain; yet what one patient considers painful is not necessarily the same as would be so considered by another. Such differences may depend upon idiosyncrasies in personality (which will be discussed in a subsequent article) but distinct differences are possible even at the peripheral perceptual level. These involve the pattern of stimulation on the one hand, and the nature of the fibers stimulated on the other. The well-known empirical differences between the pains experienced in diabetic, other nutritional, toxic, post-herpetic states, and crushing injuries, probably have a very real basis in the selective action which these particular pathologic conditions display not only for fibers of different calibre but also for particular parts of the neuron. Thus, crushing injuries tend to damage the delta-epsilon component before the C-fibers. Attention to the type of pain may provide a clue as to its cause.

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630 West 168 Street

Medical Societies Act On Smoking

The following is abstracted from results of a survey among 54 state and territorial medical societies.

More than one-third of state medical societies have taken action concerning the effects of smoking on health. A poll completed in August 1963 shows 19 state societies (36 per cent) as having passed resolutions relating to the health hazards of smoking. In addition, 5 other societies indicated that proposals for action are before committees.

Most societies urged that youth be warned about the dangers of cigarette smoking, and several specifically mentioned cooperation with school programs. Some societies called for the voluntary giving up of smoking by those addicted while others endorsed programs to warn the public of the dangers of smoking.

Other actions endorsed or proposed included: "dissemination of information"; banning of cigarette advertising in journals; "seek programs for prevention of lung cancer"; to obtain cooperation of physicians; to urge local society action; to publicize "harmful effects of tobacco"; urge action by AMA on health hazards of cigarettes.

Lung cancer was most frequently mentioned in society resolutions as having a cause and effect relationship with cigarette smoking. Other disease conditions cited as implicated or associated with cigarette smoking included coronary disease and emphysema.

Medical societies of the following states and District of Columbia have taken some action relating to health hazards of smoking: California, Delaware, Florida, Hawaii, Idaho, Maine, Massachusetts, Michigan, Minnesota, New Mexico, New York State, North Dakota, Ohio, Pennsylvania, South Dakota, Texas, Utah, and Vermont.

Nearly all state medical journals lose money. One editor here discusses etiology and prognosis—but not therapy.

Our State Medical Journals*

Can They Survive? Should They Survive?

Henry A. Davidson, M.D./Cedar Grove

Until a few years ago, nearly all state medical journals were making a profit and turning substantial amounts of revenue into the treasuries of the state societies. The tide began to turn, for some journals, as early as 1956. In New Jersey, this JOURNAL was earning a profit as late as 1960. But in 1961, and again in 1962, we had operating deficits amounting to from $1 to $2 a member. By the end of 1962, only two state medical journals (out of 40) were operating at a profit. This became a major concern among editors and business managers of state medical journals, and was selected as the theme for the October 1963 conference of editors. Dr. Davidson, our editor, was asked to talk on the economic feasibility of state medical journals. Some suggested that state medical journals be abolished and replaced by news-letters or small house organs. Another suggestion was that there be a nationally printed journal for general practitioners with a separate insert for each state which would carry local medical news and thus, in effect, become a state medical journal. A third suggestion was merger: setting up "regional" journals covering several states. (There are already two such publications: *The Rocky Mountain Medical Journal*, which represents state medical societies in Colorado. New Mexico, Utah, and Wyoming; and *Northwest Medicine*, official medical society publication for the states of Idaho, Washington, and Oregon.)

The reasons for the deficits are briefly stated here, with one editor's view: that the deficits are to be expected and are legitimate costs of medical society operations. The position here taken is simply that of the author, and not necessarily that of The Medical Society of New Jersey.

Nearly all state medical journals are losing money. I have just completed a survey of this. If we deduct subsidies and allocations of dues, we find that of the 33 journals on whom information could be tabulated, one broke even, two made a profit, and 30 had deficits. Because of differences in bookkeeping, the figures are not entirely comparable on a state-by-state basis. However, the main picture is painfully clear.

The median journal spent $12.60 per member in gross costs in 1962. Of this, $10.50 went to printing, publishing, and mailing and the other $2.00 per member went to other costs. But the median journal received only $10.00 per member if we exclude subsidies and dues allocations. In other words, there was a median deficit of $2.60 per member. Anywhere from 76 to 100 per cent of a Journal's income came from advertising.

This raises 3 questions: (1) Why are we running these deficits? (2) What is the prognosis? and (3) Should our journals survive if they can't pay their way?

Why A Deficit?

These deficits exist because costs of paper, printing, and postage have gone up faster than advertising rates. We can't reduce costs without undercutting wages. The only way to wipe out deficits is to increase income. Income from subscriptions is a negligible item for most Journals, since it is usually a dues allocation—in effect a subsidy. If out of dues, a Society allocates $1.00 one year, then allows $10.00 the next year to the Journal, it won't make any difference in the Society's balance sheet or in the member's check-book.

* Read by invitation, October 22, 1963 in Chicago at the Conference of State Medical Journal Editors. Dr. Davidson is editor of The JOURNAL of The Medical Society of New Jersey.

This suggests that maybe we should raise advertising rates. In soliciting advertising we compete with three other modalities: the drug company's detail man; direct mail advertising by the company; and advertising in specialist's journals. If we raise rates, we encourage the companies to seek alternate vehicles of advertising. The truth of this is apparent by looking at our balance sheets during the past 10 years. We have all raised rates. We have all lost advertisers and suffered deficits.

The Prognosis

During the depression, and for some of us during the war, journals went into the red. Most then became prosperous again. So why can't we assume that this is a cyclic trend, that whatever goes down must come up? And that advertising will boom and soon we will all be affluent? That would be lovely, but it won't happen. Increasing Government regulation of the drug industry will reduce advertising budgets. Also, every year the ratio of specialists in American medicine rises. Since advertisers must address themselves more and more to specialists, they are going to assign an increasing proportion of their budgets to national or specialized journals.

Service Not Profit

Thus the prognosis is unfavorable, if your yardstick is whether we will make profits for our parent societies. On the other hand, let our journals be viewed as services to members and not as profit-making enterprises. Your society may operate a doctors' placement bureau. No one expects it to run at a profit. Should your committee on ethics or any other committee be a profit-making tribunal? Your Annual Meeting may make money renting exhibit booths; if so, it competes with the journal for the advertisers' dollar. Furthermore, would anyone suggest that we give up our conventions or Annual Meetings if they don't show a profit?

Conceivably, the Journal might operate as a house organ and not as a continuing postgraduate course. If it were simply a medium of exchange for members, as a kind of verbal glue for holding the members together, you could run it at a modest cost and at trifling deficit. A "house organ" type of journal would become a channel of communication to and from officers and a bulletin board for personal and professional news. Members would become attached to it as they become attached to a favorite newspaper, and for much the same reason. I am not now urging this, except as a topic for discussion here or in the future. I am sentimentally attached to the old fashioned medical journal, and I would be reluctant to give up our scientific articles.†

Yet, essentially the state journal is the tie that binds. It is the visible thread that runs from one corner of the state to the other. It is the only such ligature. It is an opinion medium for legislative, medicolegal, organizational, economic, and administrative topics. It is the officers' way of reaching the membership; and it is the members' way of letting the officers know what they—the members—think. It is a portable bulletin board for telling the readers what's going on. Without this liaison among members, their esprit-de-corps, their feeling of professional identification, and their sense of organizational identity might well atrophy.

These are valuable services. All these a state medical journal can and should do. This is worth a few dollars per year per member—actually an average of under $3.00 a year a member. None of us need apologize for not commercializing this essential link in medicine's organizational chain.

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† During this symposium, one editor pointed out that the Society's tax-exempt status depended on its being an educational-scientific organization. The state journal was excellent evidence of the validity of this. If the journal ceased publishing educational and scientific articles, it might jeopardize this exemption.

P. O. Box 500

The Director of Pediatric Surgery at the Babies' Hospital here offers a veritable monograph on traumatic surgery in childhood.

Abdominal Injuries In Childhood*

Celestino Clemente, M.D./Glen Ridge

Nowhere in practice is surgical judgment more vital than in evaluating and treating the child who has sustained serious abdominal trauma. In these situations the best surgical treatment need not be (and more often is *not*) operative treatment, but rather repeated intelligent interpretations of frequent examinations carried out with the utmost gentleness and patience.

In children, the history of the occurrence of the injury may be unreliable possibly for fear of punishment, or because of the child's inability to communicate. The presence of frightened parents, the injuries themselves and the strange hospital environment lend more confusion to the evaluation of the signs of serious injury than in the adult. Because of these factors, an initial base line of physical findings must be swiftly established and then followed by repeated examinations at frequent intervals, preferably by the same examiner. The frequency of these observations is required by the fact that children have a more labile cardiovascular system and a smaller blood volume so that changes in vital signs may occur with startling rapidity.

Penetrating wounds of the abdomen in children should be explored by laparotomy as soon as the patient's general condition will permit. *Under no circumstances should these wounds be probed.* In stab wounds caused by knives, ice picks, or other sharp instruments there is little need for a preoperative x-ray. In injuries caused by bullets or flying bits of metallic debris (such as may be caused by rotary lawn mowers) a preoperative x-ray may be helpful in locating a retained foreign body, although one may not choose to remove it at the time of the initial procedure. All of these should come to the operating room with intravenous fluids running through a cutdown, a gastric suction tube in place, and cross matched blood available.

In exploring the abdomen where penetrating wounds have been sustained, a few basic principles should be kept in mind. The abdomen should be opened through an adequate incision. By direct inspection, see if the parietal peritoneum has been penetrated. If this is found to be the case, then a complete inch-by-inch inspection of the intestine and stomach should be done including the posterior gastric wall. To inspect the latter, the gastrocolic ligament must be opened. This is repaired before closure of the abdomen. If a hollow viscus has been perforated, there are usually an even number of openings unless the missile has ended up within the lumen. A wound of entrance and one of exit should be looked for when the bowel is found to be involved, and an accurate count of the number of perforations closed by the surgeon should be kept by the anesthesiologist. Where small bowel perforations have occurred, closure should be carried out. When the large intestine is perforated, exteriorization of the involved segment is the procedure of choice. One should not attempt closure of a colon in the presence of gross fecal contamination.

*Read before Joint Meeting of the Sections on Pediatrics and Surgery of the Medical Society of New Jersey, Atlantic City, May 13, 1963.

The treatment of injuries to solid organs and the urologic tract caused by penetrating wounds is similar to the treatment of those caused by blunt trauma, and will be discussed below.

Severe blunt trauma to the abdomen in children is most often caused by automobiles, sledding accidents, and falls. When intra-abdominal damage is caused, a solid organ such as kidney, spleen, liver and (more rarely) pancreas is most often involved. If there has been injury to a hollow viscus it is usually near a point of fixation such as the duodenum, the jejunum near the ligament of Treitz, or the ileum near the ileocecal area. The kidney, spleen, liver, small bowel, bladder, and pancreas are most often injured in that order of frequency.[1, 2, 3].

Injuries of the kidneys may be *mild* (manifested only by microscopic hematuria); *moderate*, manifested by gross hematuria; or *severe*, causing massive hemorrhage and requiring early surgical intervention. Post traumatic microscopic hematuria need be of little concern, and no treatment is required specifically for it. A child with gross hematuria following trunk trauma should be carefully watched and blood replaced as it becomes necessary. If bleeding persists in the urine beyond a few hours, an early intravenous pyelogram is essential to determine whether there is perinephritic extravasation and to see if there is a normal kidney on the non-injured side in case surgery and removal of the damaged kidney should become necessary. A large persistant blood loss is the only indication for early direct surgical intervention for even cases where a laceration of the kidney is shown by pyeolography may be treated conservatively with bed rest and antibiotics. Often complete recovery of renal function will occur even after severe damage. When emergency surgery is necessary early, it usually indicates injury to the renal pedicle. Nephrectomy then is usually inevitable. If, however, a normal contralateral kidney is not present, the control of bleeding without nephrectomy is imperative. In conservative treatment where bleeding subsides, bed rest and antibiotics are continued for from seven to ten days to prevent secondary hemorrhage, and to prevent perinephritic infection and abcess formation.

Obtaining the best possible history of the trauma and the establishment of an early base line of physical signs are imperative. Certain measures must follow in natural sequence to provide adequate observation and insure diagnosis early enough to give the best possible results. These can be listed as follows:

1. Recording of vital signs at close intervals.
2. Blood specimen obtained at time of cutdown for:
   A. Hematocrit and complete blood count.
   B. Typing and cross match.
   C. Base line serum amylase.
3. Passage of nasogastric tube.
4. Catheterization of the urinary bladder.
5. X-Rays.
   A. Chest.
   B. Flat plate, upright and lateral decubitus films of abdomen.
   C. Cystogram if blood present in first urine specimen.

The need of frequent monitoring of the vital signs cannot be overemphasized and there can be no question as to the advantage of having a cutdown in place for the administration of blood and fluids as needed.

Undiagnosed pancreatic injury following abdominal trauma is more frequent than had previously been recognized. If the trauma has been considerable, the blood amylase should be determined initially, and repeated later as indicated.

A nasogastric tube provides for immediate examination of the gastric contents. It prevents the occurrence of acute gastric dilatation which may be seen when crush injuries of the chest and multiple rib fractures complicate the picture of possible acute abdominal injury. If abdominal exploration becomes necessary, a decompressed stomach makes for easier and more thorough examination of the intraabdominal viscera.

A retention catheter should be placed in the bladder in these cases for several reasons: *first* to examine the nature and quantity of the urine obtained (if bloody, one may assume injury to the urinary tract); *second*, for accurate measurement of urinary output especially necessary during the early hours of observation; and *third*,

to facilitate a cystogram when the patient is x-rayed if the initial urine obtained contained blood.

Anteroposterior and lateral x-rays of the chest are needed in all cases of abdominal trauma, since chest injuries often accompany and may in themselves produce symptoms and signs which mimic acute abdominal injury. Awareness of an accompanying hemopneumothorax —for example—and the carrying out of tube thoracotomy for it prior to laparotomy for acute abdominal injury may tilt the balance in favor of the patient. Flat, upright and lateral decubitus films of the abdomen are then taken. If the initial urine obtained had been bloody, a cystogram should be carried out. If the bladder is found intact in the presence of gross hematuria, an intravenous pyelogram may be done if the condition of the child will tolerate it since children do not require bowel preparation and dehydration for pyelography.

Abdominal diagnostic paracentesis with a short beveled 18 or 19 gage needle has been recommended in recent literature. Some still question its value, feeling that the risk of false interpretation is great and that information obtained from it may be obtained by other means[4]. I feel that this procedure has merit and should be used especially in cases where, for reasons of other associated injuries (i.e., head or chest), there may be some difficulty in eliciting signs of a worsening intra-abdominal condition or in their interpretation. In these cases a paracentesis may give the indication for laparotomy at the earliest possible moment.

The most important signs which indicate necessity for exploration other than pneumoperitoneum or hemoperitoneum are a progressive increase in pain, tenderness and rigidity, and a decrease in peristalsis by auscultation.

Obtain repeated (i.e., hourly) examinations of hematocrit and hemoglobin levels. However, dependence on these values should be limited and influence you only if they show definite decrease. Even severe bleeding may not be reflected in their values because of initial vaso-constriction. Several authors emphasize the white blood cell count as a diagnostic criterion of considerable value. Berman[5] states that a level above 15,000 immediately following trauma is indicative of rupture of spleen or liver, while Williams and Zollinger[2] feel that a level above 20,000 is a most helpful criterion in deciding whether exploration is indicated. At our hospital† only two of the last four cases of traumatic rupture of the spleen have had initial white blood cell counts of over 15,000. I feel that a count of 15 to 20,000 in the early period of observation might influence the decision in favor of exploration. Absence of such a finding should not be relied on. It may give a false sense of security.

Many surgeons have praised abdominal x-rays as helpful in rupture of the spleen or liver; but most of these reports deal with adults. Loss of splenic outline, enlargement of splenic shadow, and loss of renal shadow have been described as well as a sawtooth type of defect along with the greater curvature of the stomach (from hemorrhage into the splenic pedicle)[6]. These x-ray signs add to the case for exploration; but their absence should not deter one if the physical signs are progressive. The indications for exploration may therefore be tabulated as follows:

1. Pneumoperitoneum.
2. Positive diagnostic abdominal paracentesis.
3. Increase in pain, tenderness, rigidity and decrease in peristalsis.
4. The onset of signs of shock or continued unexplained shock after proper resuscitative measures.
5. Drop in hematocrit and hemoglobin.
6. White count of 15,000 to 20,000 soon after trauma.
7. X-rays suggestive of increased size of splenic shadow.

Cases of trauma to the abdomen *not* associated with severe intra-abdominal injury usually improve within a few hours. If this occurs, one may relax his vigilance somewhat; but these children should be kept under observation for seven more days. Although delayed rupture of a solid viscus is rare, it can and does occur.

Lacerations or perforations of the stomach and small intestine should be closed primarily. This treatment may extend even to injuries to the right side of the colon where contamination has

† Babies Hospital Unit of the United Hospitals of Newark.

not been prolonged or extensive, but openings in the transverse or left colon where the contents are more solid should be treated by exteriorization of the involved segment and temporary colostomy.

Injuries to the spleen should be treated by splenectomy. Care should be taken to remove *all* splenic fragments. If injury to the pancreas has occurred in the form of contusion, no direct surgical treatment is carried out. If the body of the pancreas has been transected where it crosses the vertibral column, then a distal pancreatectomy should be done as recommended by Hannon[7] to prevent the formation of pseudocysts. Benson, Mustard[8] *et al* describe an innovation in the treatment of children with rupture of the liver. This involves the use of hypothermia which enables the surgeon to clamp the hepatic artery and portal vein for periods as long as twenty minutes while either partial hepatectomy is done, or bleeding is controlled with mattress sutures of heavy silk. All of these cases should be drained since some bile peritonitis is inevitable. Mortality in children with rupture of the liver has been high, running about 40 per cent. It is hoped that the new technique may bring about some reduction in this future.

Summary

1. The early recognition and treatment of injuries to abdominal viscera in children is imperative to obtain optimal results.

2. All cases of penetrating wounds of the abdomen should be explored surgically.

3. Indications for exploration following blunt trauma to the abdomen are:

(A) Pneumoperitoneum; (B) Positive abdominal paracentesis; (C) Increase in pain, tenderness, rigidity and decrease in peristalsis; (D) The onset of shock or continued shock after proper resuscitative measures; (E) A drop in the hematocrit and hemoglobin; (F) White Count of 15,000 to 20,000 soon after trauma; (G) X-rays suggestive of increased size of splenic shadow.

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364 Ridgewood Avenue

*Nonsmoking Physicians Do Not Get Lung Cancer

A five-year study of mortality among physicians in Massachusetts compares lung cancer death rates of smokers and non-smokers.

No signficant differences in lung cancer death rates were observed between "reply" and "no reply" groups, the standardized rates being 38 per 100,000 population for the former and 37 for the latter.

Among physicians who did not smoke at the start of the study, *there were no deaths from lung cancer.* The lung cancer death rate for all physicians who smoked was 61. and for physicians who smoked only cigarettes, it was 96 per 100,000 population.

**Survival of Massachusetts Physicians According to Smoking Habits.* Snegireff, L. S., and Lombard, O. M.: Harvard School of Public Health. Cancer, 16:212 (1963).

The Medical Society of Atlantic County recently conducted a successful recruitment forum on "Medicine as a Career."

An Experiment In Medical Manpower Recruitment

John W. Holland, M.D./Margate City

The Medical Society of Atlantic County issued an invitation to boards of education, faculties and students of Atlantic County schools, to members of the county medical society, to Atlantic City service clubs, and to the Atlantic City Chamber of Commerce. They were invited to participate in a forum on "Medicine as a Career" being given to three audiences: two to students and one to invited guests, numbering well over a total of three thousand persons. All were held at the Atlantic City High School. This experimental recruitment forum resulted in a many-fold increase in student requests for further information concerning the details of the education of the physician and of his technological assistants. Similar forums are planned for the future.

The Program

Dr. Morton Major, president of the Medical Society of Atlantic County, opened the formal program with general statements of the problem of the shortage of medical manpower and of the physician's opportunities and rewards.

Dr. John W. Holland, vice-president of the Society, introduced the next three speakers: (1) The Principal of the Atlantic City High School, Albion G. Hart, who outlined the premedical education of the physician at the high school and college levels; (2) Robison D. Harley, M.D., who presented the requirements for admission to, and for graduation from, medical school; and (3) Hilton S. Read, M.D., who discussed the physician's continuing education after graduation from medical school, during internship, residency and practice.

The forum was then opened to discussion and questions from the audience, Dr. Holland presiding. The ideas developed in the question-and-answer period have been combined with those of the three formal presentations, and supplemented by pertinent, documented, statistical and other data from the medical literature. This total material has been synthesized, correlated, and organized here into a form which will be useful to other societies planning similar recruitment forums.

The Manpower Deficiency

For the past several years, organized medicine has been aware of the increasing shortage of physicians, nurses, and medical technologists. Numerous recommendations have been offered, chief among them being immediate increase in recruitment, by all possible means (such as the forum here described) of well-qualified, enthusiastic young men and women.

Of the 250,000 physicians in the United States, more than one-third are retired, in administrative and research posts, or otherwise "not in practice," leaving but 91 physicians per 100,000 population to deliver actual medical care to the people. In 1940 there were 108 practicing physicians per 100,000 population. In 1975, when the present, medically-oriented high school student will be ready to practice, the total nummer of clinicians (allowing for the greatly increasing drift of physicians into research[16],

teaching, administration, the Armed and other Government Services) will be less than today. All these factors result in a situation highly detrimental to the health of the nation[1].

Among the "not-in-practice," fixed-income, salaried opportunities for physicians are research (cancer, space medicine, nuclear energy and so on) hospital administration, Armed Forces, Veterans Administration, U. S. Public Health Service, foreign service, insurance companies[15], pharmaceutical houses, medical and surgical instrument and supply houses, medical writing and editing, administration in national and international medical societies and associations, voluntary health foundations[13] (cancer, heart, arthritis, cytology, muscular dystrophy, and a hundred others), state, county and municipal health departments, and industrial medicine and surgery.

It is interesting to note that research scientists with a medical degree earn $5,000 a year more than those without it, according to the National Register of Scientific and Technical Personnel[12].

Medical education in this country now fails to produce enough physicians to provide medical care to the public. Increased recruitment of medical students (as by this forum), increased ultilization of present medical school facilities, and development of new medical schools (as has recently been done in this state) are the real problems.

It has been said that medical schools are not as efficiently conducted as are industrial plants. Medical school facilities usually lie practically idle one-third to one-quarter of the year. Use of these plants on a twelve-month basis would reduce the medical course from four to three years and yield a 25 per cent increase in physician production.

Size of classes, also, could be increased[14]. In 1960, the 85 medical schools in the United States graduated 7,081 physicians; the 68 medical colleges in Russia graduated more than 14,000 a year. More than half of these were women. Doctor Harley stressed that a greater acceptance of women applicants would do much toward correcting our deficiency. The Medical College of the University of Paris alone graduated 1,000 physicians in 1960—one-seventh the number graduated from all 85 American schools put together!

American medical schools have 54,270 full-time and part-time teachers and 30,203 students —two teachers to one student. More than 600 budgeted faculty positions remain vacant. American dental schools have 4,500 teachers to 14,800 students—three students to one teacher[1].

The 7,081 medical graduates in 1960 exceeded the 1935 class by only 27 per cent. In the same period, the population increased 45 per cent.

The New York Board of Regents approves medical education in Italy, Switzerland, France, Holland, Belgium, and Ireland. Each year 400 to 500 Americans are graduated as physicians from the institutions in these countries. In the decade beginning in 1952, more than 14,000 foreign physicians immigrated to the United States[4].

Obstacles to Recruitment

Many factors contribute to the decreased interest of the teenager in a medical career. Not the least of these is the increasing, persistent, and pernicious pressures, particularly at the national level, toward socialization or nationalization of the American medical system.

The doctor's son of today is often no longer interested in carrying on the family tradition, perhaps of many generations of physicians. On radio, in newspapers, and lay magazines[2] he hears and reads of the persistent downgrading of the prestige of his ancestors' profession;[2, 7], and he turns to law, engineering or commerce, or even a trade, where in five to seven years less time he can be on a self-sustaining basis, with much less strain on the family exchequer.

The recent Congressional investigation of the pharmaceutical houses (spilling over to include hospital and physicians' charges) has not enhanced public opinion of American medicine, even though it has been shown that costs of medical care, in and outside the hospital, have increased *less* than costs of other services and commodities.

The medical profession itself is not without blame for decreased medical school applications.

The unstandardized requirements of state boards, national board and specialty boards, of licensing, of interstate endorsement, and increasing complex regulations of medical practice, hospital appointments and accreditation —all introduce further deterrents to the choice of a medical career. The high school student early becomes infected with American labor's great interest in short hours, five-day week, six-hour day, coffee breaks, long vacations with pay, early marriage, and health and other fringe benefits. Thus he may shy away from medicine as a thankless drudgery.

Dr. Harley pointed out that one of the obstacles is the cost of medical education. Organized American medicine at county, state and national levels is taking steps to meet this difficulty. As an example, the Medical Society of Atlantic County has a functioning loan program for local needy medical students. The goal of the Medical Society of New Jersey's Student Loan Fund is $100,000. In 1960 it had reached the $51,000 mark[11]. The Guarantee Loan Program of the American Medical Association's Education and Research Foundation[3] permits a student, intern, or resident to borrow from a local bank $1,500 in any one year, up to a total of $10,000 over a seven-year period, with no payments of interest or principal until five months after entering practice or full-time employment. This plan in a few years will become self-sustaining from repaid loans, and should prove valuable in stimulating interest in medical careers. *No worthy individual need be denied a medical education for lack of funds*[8].

Another obstacle to physician recruitment is the long grind through college, medical school, internship, and residency. But the anticipation of these difficult periods is often more appalling than their realization.

Education

Mr. Hart cautioned the teenager deciding on medicine as a career to guard against one-sided training, against giving too much time and effort to the biologic sciences to the exclusion of the humanities, art, literature, languages, and especially the art of communication, called English in high school and college. Every physician should be able to communicate effectively and to express himself intelligibly. This is not possible if his education is limited largely to purely scientific, biologic, and medical training. He must know the classics in his own and other languages. Unless the physician is satisfied to be a mere skilled technician or a vocationally trained individual, he must have a broad education in non-scientific fields.

In outlining the admission requirements for approved medical schools, Dr. Harley noted that three years college preparatory study is the minimum in most states. The Council on Medical Education and Hospitals[10] recommends four years. Exceptional students may be admitted after two years of college. The requirement in New Jersey is for two years pre-professional training after high school. Some states (as Georgia and Missouri) still require only a high school diploma.

Several medical schools have plans for allowing talented students to begin medical studies—the scientific, non-clinical branches—in the second or third college year, and thus obtain the bachelor and medical degrees in six or seven years instead of the conventional eight years. For exceptional students, some schools (including the Jefferson Medical College) telescope the four eight-month years into three twelve-month years by eliminating summer vacations.

The high school student aiming at a medical career should make every effort toward superior scholarship so that he may enter college with a good record. And in college, he again should strive for top-rank scholarship so that he may creditably pass the Association of American Medical College's official entrance examination, or qualify otherwise for admission. Dr. Harley states that formerly only A and a few B students were admitted; but today, B's predominate with a few A's and C's. The choice opportunities—internships, fellowships, and residencies—still go to the graduates with the highest school averages.

Counsel to the medical aspirant still in high school would be incomplete without reference to physical as well as mental development. Medical courses and medical practice are not for the weakling, and require *mens sana in*

corpore sano. The medical aspirant and student should not neglect physical education, athletics, body hygiene, and prevention of diseases, especially venereal. Alcohol and tobacco, he suggested, should be avoided entirely. Coach's training restrictions should be followed throughout the year. With the danger to heart and lungs from cigarette smoking, many physicians are giving up the habit. The sensible and observant teenager will not start it; or will stop now while he can, because for the practice of medicine, he must have a "steady hand and the heart of a lion."

Where, outside Absecon Island, is there such opportunity for perfect physical development of youth! Count of Atlantic County physicians who were lifeguards in their youth would be interesting. Many of us, on the beaches, in the surf, and at the oars, accumulated the physical stamina that carried us through the grind of medical education and into the still more grueling practice of medicine.

The Paramedical Professions

Highschool students who would be overburdened financially or otherwise by the prolonged educational requirements for medical practice and who still want to be in medical work have a large selection of occupations supplemental to the practice of medicine. Mr. Hart reviewed that educational preparation and training in the paramedical sciences, dentistry[5], veterinary medicine, nursing and pharmacy require less time and less financial investment than medicine. A recent Government-sponsored report recommends a 75 per cent increase in nursing personnel. To obtain this goal, 6 per cent of all girl highschool graduates would have to be recruited.

The Ancillary Technologies

Still less preparatory investment is required for many auxiliary branches of medical technology, some of which have well-organized local, state, and national societies with periodic educational meetings and conventions, and with special journals. Members of some of the groups are awarded diplomas, certificates, and degrees by appropriate bodies. Personnel shortages exist in all these accessory fields. There are now more than 700 approved schools of medical technology in hospitals throughout the country.

Among these numerous fields of supplemental medical technology[6] are: clinical laboratory, biochemistry, urine analysis, blood analysis, pathology, histology, tissue preparation, frozen sections, tissue culture, hematology, bacteriology, serology, parasitology, virology, mycology, microbiology, exfoliative cytology, genetics, experimental physiology, experimental pathology, experimental pharmacology, blood transfusion, blood bank, autopsy, basal metabolic rate, electrocardiology, spectrophotometry, chromatography, serum electrophoresis, phase microscopy, electron microscopy, radioisotopes, antibiotic sensitivity, hay fever, allergy, pregnancy testing, medical library, medical record library, practical nurse, dietetics, vitamins, occupational therapy, rehabilitation, physical therapy, audiology, speech correction, orthoptics, optometry, podiatry, x-ray, orthopedic appliances, prosthesis, social service, guidance counselor, medical administrator, dental technician, physician's office assistant, medical secretary, medical stenographer, and medical stenotypist.[9]

Conclusions

This forum, presented to over three thousand students, stimulated an active interest in medicine and its allied fields. This was demonstrated by the interesting context of the more than three hundred written questions received from these students. Their contents indicated lack of knowledge and understanding of medicine from the highschool level to actual practice of the art, necessitating additional forums of this type to educate and stimulate the future physicians and medical personnel. A particular reward of the forum was the notification that eight able students who previously had not even considered medicine as a career have now directed their studies to this field.

Dr. Read summed up the meeting with the following: "There are four great days in a doctor's life—one when he receives his Doctor of Medicine degree; next when he marries, to be followed by his first view of his first born; and, finally, the day his friends pay him their departing respect. But don't worry about that last one as there is no Hell for doctors. They catch it all here on Earth."

The interesting scope of medicine necessitates constant study, more and more narrow specialization, and the enlistment of many technologists of all educational levels whose activities the physician must direct in a concerted effort to conserve the health of the nation—"our country's most important resource."

A bibliographic list of citations will be found in Dr. Holland's reprints.

4 South Haverford Avenue

The vague phrase, "shortness of breath", is not enough. Clinicians here are offered a more precise and usable yardstick.

Clinical Estimation of Breathlessness*

Burton M. Cohen, M.D./Elizabeth
(with the technical assistance of Carl Crandall)

"Fortunately, there was not far to go, and David Bean ran the rest of the way. Paul, restricted by his limited breathing capacity, managed no more than slightly to increase his pace."

A. E. Ellis, THE RACK[1]

The emergence of chronic respiratory disease as a formidable cause of death and disability in this country is now beyond cavil[2]. Clinicians, busy with the more prevalent acute respiratory ills, can no longer ignore asthma, chronic bronchitis, respiratory tract malignancies, tuberculosis and diffuse obstructive pulmonary emphysema. These crippling conditions will be of increasing significance over the coming years[3,4]. Objective means of estimating the presence and degree of pulmonary disability are crucial for sophisticated management and appraisal of the natural history of these diseases.

Physical examination of the chest[5,6] and radiologic[7,8] opinion [9,10] (even in expert circles) have been so influenced by observer error and variation[11] as to be less than reliable criteria. Spirometric measurements, often more helpful than roentgenologic examination[12], are qualified by an overlap of 15 to 20 per cent between normal and abnormal subjects[13]. For these reasons, various clinics have been engaged in the assessment of clinical and physiologic means for the estimation of respiratory disability. Our own preliminary observations[14] suggested the value of categorizing the patient's complaint of breathlessness as a determinant of ventilatory disability and confirmed the utility of the Snider "match test"[15, 16, 17, 18] in this functional separation. We have now amplified our analysis of the historical data gathered from patients concerning their breathlessness and the circumstance of its occurrence.

Materials and Methods

The subjects were 300 patients with a variety of bronchopulmonary diseases referred either to the Thomas J. White Cardiopulmonary Institute or the private office of the author by the Bureau of Old-Age, Survivors, and Disability Insurance† during the 3-year period beginning January 1, 1960. There were 234 men and 66 women, ranging in age from 22 to 65 years.

After the clinical interview, each patient was classified according to the 5 grades of dyspnea popularized by Fletcher[19]:

1. Performance on walking and climbing hills and stairs as good as that of other persons of similar age and build;
2. Normal performance on walking, but inability to keep up with others on hills or stairs;
3. Ability to walk a mile or more at own speed, but inability to keep up with others;
4. Inability to walk more than 100 yards without a rest; and
5. Breathlessness on talking or undressing and inability to leave the house.

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Presented at the 197th Annual Meeting. The Medical Society of New Jersey, May 13, 1963, Atlantic City, New Jersey.

†State of New Jersey Disability Determinations Service, Newark 2, N. J.

Pulmonary function studies were performed with the patient seated, according to the protocol of Baldwin and associates[20]. The apparatus was the standard 9-liter Warren E. Collins respirometer††. All values were corrected to body temperature and ambient barometric pressure, saturated with water vapor[21]. The terminology for these measurements followed the recommendations of the American College of Chest Physicians[22]. The FEV was expressed as the percentage of the actual forced vital capacity which could be exhaled in the first second[22] and also as a percentage[23] of the predicted normal[24] FEV. The Air Velocity Index was calculated by Gaensler's formula[25]. The data were the averages of two duplicate-check determinations performed during a single session.

Results

TABLE I

DISTRIBUTION OF 300 PATIENTS ACCORDING TO NUMBER, SEX AND MEAN AGE FOR EACH GRADE OF DYSPNEA

Grade	Number	Men	Women	Mean Age
I	39	25	I4	41.2
II	100	80	20	46.4
III	9I	78	13	50.2
IV	50	35	15	57.0
V	20	16	4	55.8
all grades	300	234	66	

Table I presents the distribution of the 300 patients by number, sex, and mean age for each grade of dyspnea. Thirty-nine patients fell into Grade 1; 100 into Grade 2; 91 into Grade 3; 50 into Grade 4; and 20 into Grade 5. Although the average ages of the patients in Grades 1 and 2 were below those in Grades 3, 4 and 5, the size of the groups was disparate, and the rise in age with increasing breathlessness was irregular. Table II lists the patient distribution and the forced vital capacity, maximal voluntary ventilation, FEV and Air Velocity Index averages at each clinical level of breathlessness. The average value for the forced vital capacity and maximal voluntary ventilation fell steadily and more rapidly than the trend of the predicted values for these tests as breathlessness became more severe. The group average FEV declined from 75.5 per cent of the forced vital capacity for patients in Grade 1 to 55.6 per cent for patients in Grade 5. There was no distinguishable trend of intergroup variations in Air Velocity Index average figures.

TABLE II

CORRELATION OF GRADES OF DYSPNEA WITH AVERAGE VENTILATION FUNCTION (300 Patients)

Breathless Grade		Vital Capacity in cc		M.V.V.* in l/minute		A.V.I.*	F.E.V.$_{1.0}$* in per cent
Grade	Number	Predicted	Actual	Predicted	Actual		
1	39	3285.4	3109.5	107.7	101.8	0.94	75.5
II	100	3521.6	3371.6	104.6	67.7	0.69	67.7
III	91	3670.9	2839.6	106.1	64.2	0.81	64.6
IV	50	3404.1	1996.3	92.3	42.3	0.78	61.3
V	20	3139.0	1371.6	90.8	33.6	0.92	55.6

* M.V.V. represents the maximal voluntary ventilation, A.V.I. the air velocity index and F.E.V.$_{1.0}$ the forced expiratory volume for the first second of the forced vital capacity.

Table III presents the data reclassified on the basis of the frequency of certain discrete test abnormalities at each grade of breathlessness. The behaviour of the 139 patients in Grades 1 and 2 is compared with that of 161 patients in Grades 3 to 5, inclusive. Each of the individual functional derangements was more frequent among patients in the higher categories of dyspnea. There was a steady rise in the frequency of individual function abnormalities with increasing difficulty in breathing. The vital capacity results were the most striking in separating the less dyspneic patients from those who were more breathless. Every patient in Grade 1 and 2 surpassed 70 per cent of his individual predicted value for this test, while only 37.3 per cent of those in Grades 3, 4, and 5 bettered this prediction figure.

TABLE III

CORRELATION OF GRADES OF DYSPNEA WITH OEPRESSED VENTILATION FUNCTION (300 Patients)

Breathless Grade*		V.C.** below 70% of predicted		M.V.V.** below 70% of predicted		F.E.V.$_{1.0}$** below 70% of predicted	
Grade	No.	No.	% Abnormal	No.	% Abnormal	No.	% Abnormal
1	39	0	0	1	2.5	1	2.5
II	100	0	0	23	23.0	13	13.0
III	91	41	45.0	49	53.8	53	58.2
IV	50	40	80.0	28	56.0	30	60.0
V	20	20	100.0	20	100.0	14	70.0
Total	300	101	33.6	121	40.3	111	37.0

* After Fletcher
** V.C. represents the vital capacity, M.V.V. the maximal voluntary ventilation and F.E.V.$_{1.0}$ the forced expiratory volume for the first 1.0 second during performance of a forced vital capacity.

Discussion

Prolonged, aggressive, and comprehensive therapy instituted after early diagnosis of chronic respiratory disorders may result in the ameliora-

††Warren E. Collins, Inc., 555 Huntington Ave., Boston, Mass.

tion or reversal of the disease and prolong life[26]. Bronchopulmonary conditions are commonly unrecognized in their milder and beginning forms and sometimes overlooked in the most advanced stages; case detection by the clinician presently leaves much to be desired[27]. Of the two chief complaints, cough and breathlessness, which bring those afflicted to the physician, shortness of breath appears most susceptible to precise description.

Progress in our understanding of the nature of dyspnea, as well as new definitions and classifications of this symptom, have been extensively reviewed[28-38]. Shortness of breath can appear in both well and abnormal subjects when the ventilatory demands of the body cause the respiratory muscles to perform an excessive amount of work[39]; the responsible mechanism may be an alteration in muscle fiber length inappropriate to the change in muscle tension (force) developed[40]. As effort intolerance worsens, arterial oxygen desaturation and carbon dioxide retention become more common[41,42]. Although spirometric analysis may be the most sensitive guide to the degree of disability in our breathless patients[43] and various function studies agree closely with symptoms and inability to work[44-50], no single test or statistical combination from a battery of studies furnishes a reliable assessment of the level of physical performance at which dyspnea is unequivocally seen[51]. The problem can be sometimes resolved by using the patient as his own control and following his respiratory function with serial measurements[13], but this may not be entirely satisfactory because many individuals with respiratory disturbance experience a variable breathlessness throughout the day, in certain seasons of the year[52] or during weather changes[53]. Generally, disability appraisal requires us to subject the breathing apparatus to the stress of exercise for a valid estimate[54], and here the patient's symptomatic discussion of his own condition is extremely helpful because the baseline is his own previous personal state of performance and not a predicted statistical "normal" value.

Our experience suggests that the use of Fletcher's criteria for dyspnea[19] offers the clinician a reasonably accurate insight into the state of ventilation performance which can be recorded from the details of the history alone before resort to laboratory measurement. In our group, impairment of the maximal voluntary ventilation greater than that of the forced vital capacity and reduction of the volume of air exhaled forcibly in the first second are indicative of the obstruction to expiratory airflow or diminution of pulmonary elasticity[55] to be expected in these patients with bronchitis[56], asthama[57], tuberculosis of the lung[58] and diffuse obstructive pulmonary emphysema[59]. Patients in the lower two grades of dyspnea tended to be younger and to have better lung function than those in Grades 3, 4, and 5 of this classification. All patients with depressed vital capacity results fell into these three higher grades of breathlessness. The FEV was the second best means of separating patients with poor respiratory function from those with relatively intact performance, 97 of 111 (87.3 per cent) with low values falling into Grades 3, 4, and 5 of the Fletcher scheme; the other 14 falling into Grades 1 and 2 (12.7 per cent false negatives). Although this 1 second timed vital capacity derivative has a high correlation with the maximal voluntary ventilation[60-63], the grading of dyspnea was not as clear-cut in discerning alterations in the latter measurement. Ninety-seven of 121 patients (80 per cent) with low maximal voluntary ventilation figures fell into Grades 3, 4, and 5, while 24 patients with reduced performance would have been expected to have good function from their inclusion in Grades 1 and 2, an incidence of 20 per cent false negatives. While these results are not of the high order of statistical correlation found by Fletcher in a recent tabulation[64], they do suggest that most patients in dyspnea Grade 3 or above can reasonably be expected to have low ventilation values. Patients included in these three higher grades of breathlessness may then be examined by means of simple lung function apparatus available to any physician in his own office[65] for a more quantitative functional division.

Summary

1. Three hundred patients with a variety of pulmonary diseases have been classified on the basis of certain ventilation studies and the cri-

teria (Fletcher) of the British Medical Research Council for grading the severity of dyspnea.

2. Although there was a widespread overlap for each ventilation measurement, there was a progressive deterioration of forced vital capacity, FEV and maximal voluntary ventilation with increasing grades of breathlessness. Patients in Grades 1 and 2 tended to be younger and had better average measurements than those in Grades 3, 4, and 5. The signal difference was in the forced vital capacity. All 101 patients with figures for this test below 70 per cent of the predicted value fell into Grades 3 to 5, inclusive, of the classification of dyspnea. This classification was not as helpful in separating patients with reduced maximal voluntary ventilation figures or forced expiratory volumes for the first second, 19.9 per cent and 12.7 per cent, respectively.

3. This study suggests the value of precision in questioning the patient with shortness of breath as a means of estimating ventilation disability.

The Grades of Dyspnea*

I. The patient's breath is as good as that of other men of his own age and build, at work, on walking and on climbing hills or stairs.

II. The patient is able to walk with normal men of his own age and build, on the level, but is unable to keep up on hills or stairs.

III. The patient is unable to keep up with normal men on the level, but is able to walk about a mile or more at his own speed.

IV. The patient is unable to walk more than about 100 yards on the level without a rest.

V. The patient is breathless on talking or undressing, or is unable to leave the house because of breathlessness.

A bibliographic listing of 65 citations appears in the author's reprints.

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*Fletcher, C. M.: Proc. Roy. Soc. Med., 45:577, 1952.

230 West Jersey Street

New New Jersey ACS Fellows

The American College of Surgeons announces the induction into its Fellowship of the following New Jersey surgeons. The convocation was on November 1, 1963:

Atlantic City
Daniel R. DeMeo

Bound Brook
Maxwell Borow
Frederick L. Perl

Clifton
Dean A. Wry, Jr.

Denville
Robert E. Davis

East Orange
Michele A. Chiechi
Clement A. Furey, Jr.

Elizabeth
Richard S. Battaglia
Anthony D. DiBenedetto
John K. Donahue
Ralph E. Sweeney

Englewood
Robert T. Potter
Francis P. Salvatore

Glen Ridge
Robert J. Brinning

Hammonton
Andrew F. Jannett

Jersey City
James L. Breen
Kenneth W. Mahan

Lawrenceville
Francis U. Seiler

Long Branch
Pascal L. Federici

Newark
Anita Falla
Christine E. Haycock
Bruno V. Manno
Traudel E. Pannullo
Richard C. Reed

Passaic
Carl Rasin

Paterson
Jerome Bellet
John W. Bromley
Paul Phillips
E. Robert Wilson

Point Pleasant
Edward M. Lance

Pompton Plains
Mitchel Bernstein
Dominic A. Kujda

Princeton
James B. Hastings

Red Bank
Raymond L. Cunneff, Jr.
Allen B. Kendall

Ridgewood
Almerindo G. Portfolio

Vineland
Frank Porcaro

Wyckoff
Charles A. Rentrop, Jr.

Dr. Dukelow is Assistant Director of the AMA's Department of Community Health and Health Education, and here presents a modern and imaginative view of the school physician's role.

What is the School Physician's Real Role?*

Donald A. Dukelow, M.D./Chicago, Ill.

"Resolved, that, in the opinion of this Association, medical men ought to have a voice in the construction and location of public school buildings, in the question as to the age at which children should be admitted, the hours of study, and the general management of these institutions; and to this end, it is believed to be necessary that one or more intelligent physicians should be placed upon . . . boards having the control of public education and schools."[1]

This 1878 opinion of the AMA House of Delagates is just one of the early reflections of the need for physicians in the schools and the development of school health service practices that are both medically and educationally sound. Other opinions have been expressed in the past half dozen decades by innumerable individuals and by such recognized authorities as the Joint Committee on Health Problems in Education of the NEA and AMA, these two associations independently, the American School Health Association, the School Health Section of the American Public Health Association, the American Academy of Pediatrics, the National Congress of Parents and Teachers and the U. S. Public Health Service, to mention only a few. In spite of this evidence of interest, no curriculum has been developed for the professional education of physicians in school health administration except for a few large cities which have a training program for their own staff members.

School physicians have "just growed." They learned their administration by administering. The clinician brought his clinical practices into the school because his interest was in clinical medicine. The physician with a preventive medicine background stressed prevention, immunization, sanitation. A few have been concerned with health education.

The school health service program that becomes established is the resultant of many component forces—the physician's idea of his role, the school administrator's concept of health programs in schools, the community support for the program, and the reaction of the local physician group to another physician seeing their child patients under the protection of government. This becomes increasingly complex if the school physician divides his time between serving his colleagues and their patients as a health officer for the school and competing with these physicians in the private practice of medicine.

What I say here about desirable policy and practice is largely my opinion distilled from years of observation, supplemented by the opinion expressed by various groups who may suggest and recommend but not direct or command.

Recommended School Physician Practices

The school physician, school medical officer, school medical inspector, school health advisor,

*Presented at the Symposium on School Health, March 27, 1963 at New Brunswick, N. J.

[1]Blasingame, F. J. L., *Digest of Official Actions*, 1846 - 1958, American Medical Association, p. 102, Resolution approved by the House of Delegates, June 1878.

or whatever title you use, is basically a medical administrator. The 1947 Conference on the Cooperation of the Physician in School Health[2] (later to be known as the "First National Conference on Physicians and Schools") noted that "all schools must have a school physician who will function as a school medical advisor." His recommended functions included assistance in establishing sound school health policy; advice to school administrators regarding health supervisory activities; coordination of school health services with community health programs; formulation of procedures for communicable disease control in cooperation with the health officer and school administrator; making medical examinations to discover defects; to determine fitness for school activities and to note the need for modification of pupils' school environment or program; advising parents as to the correction of defects through the utilization of community resources; advising school authorities in the maintenance of a healthful school environment; carrying out a health service program which is educational in nature; acting as a consultant in the development of a vital functioning health education program and working with community groups to assure the availability of necessary professional health services for all children. It was emphasized that medical examinations are not the only function or even the principal function of the school medical advisor.

Two years later the Second National Conference on Physicians and Schools[3] defined a school physician as a "Doctor of medicine who has been officially designated by appropriate authority to render specified administrative, medical, and educational services in one or more schools, either part-time or full-time, voluntary or paid." His position should carry a salary commensurate with the responsibilities of the position irrespective of the source of such salary. He should be a recognized member of the administrative staff of the school, included in faculty and health council meetings and administrative staff meetings. He should be given, and accept, responsibility for in-service education of teachers in matters pertaining to health and serve as a consultant in the preparation of curriculum material in the field of health. The medical profession should accord the school physician the respect usually accorded to physicians limiting their practice to preventive medicine or other accepted public health services.

Where the school physician suffers a lack of status, it most frequently is due to a lack of the administrative and public health training or experience necessary to perform the diverse functions required. The status of the school physician and the program he administers is a reflection of the degree to which he coordinates his program with existing patterns of medical and educational practice.

The American Academy of Pediatrics, Committee on School Health, prepared a 1959 statement[4] which discusses, among other things, the school physician's function. The Academy feels that he should be a medical *advisor* rather than a source of *medical care*. He is a liaison between the school and the community health agencies and physicians. He advises the school staff on medical matters, and advises parents and children as to the facilities which exist for solving their medical problems. Though he promotes indicated immunization procedures, he has them done (insofar as possible) by the child's personal physician or local health department. The school physician should *not give treatment* except for first aid and emergency treatment. He should discover the child who needs medical attention and guide parents to their private physician or other community health service. He may aid and supplement the private physician in his care of the child through his greater opportunity to suggest needed educational and recreational modifications to both private physician and parents. The school physician also has opportunity to act as a counselor on health curriculum content, health instruction and environmental sanitation.

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[2]Smiley, D. F. and Hein, F. V.: Report of Conference on the Cooperation of the Physician in School Health, October 1947. American Medical Association. Third Printing, 1951.

[3]Hein, F. V. and Dukelow, D. A. "Report of the Second National Conference on Physicians and Schools," October 1949, American Medical Association, Second Printing, 1950.

[4]Maksim, George, et al: "Committee on School Health, School Health Policies," *Pediatrics*, 24; No. 4 (October 1959)

The American School Health Association inquired of its Fellows as to their concept of the responsibilities of school physicians[5]. Of the 95 statements of responsibility offered in the questionnaire, the ones rated most often in the top ten ranks stated that the School Physician:

"works closely with school nurses to facilitate coordination of the health service program;"
"belongs to and participates in national, state, and local medical organizations;"
"encourages pupils to have medical examinations done by a family physician when needed;"
"encourages parents to have their children immunized;"
"assists in planning policies and procedures for emergeny care, such as victims of an accident or sudden illness;"
"assists and cooperates with school and public health officials in the exclusion and readmission policies of the communicable disease program;"
"encourages periodic medical examination of handicapped pupils by the family physician or other community resources to determine their physical status;"
"participates in or consults with local medical societies;"
"participates in public health programs to promote the coordination of school and public health programs."

The responsibilities reported as *practiced* most were the same as those listed above, except for the deletion of the one stating "the school physician works closely with the school nurse," and the addition of three stating that the school physician:

"performs medical examination of children referred by the teacher or nurse for a specific health problem;"
"conducts periodic medical examinations of pupils not examined by private physicians;"
"conducts medical examinations of athletes."

These three ranked respectively 25, 29, and 47 in a total of 95 responsibilities.

Little has been added to the concept of school physicianry since these functions were outlined. Even when serving part-time in a limited school health program, a physician is expected to rise above being the simple "examiner" and to be a positivc, constructive influence on the entire school health program. His greatest usefulness is as an interpreter and liaison. As a physician understanding medical practice, he is in an unusual position to interpret to school administrators, teachers, and other school personnel the peculiar problems met by physicians in the management of their child patients. He should enlist school cooperation with the child's personal physician in altering the child's school program to meet his individual needs. Likcwise, as a person knowledgeable about thc administration of schools and the operation of various study and activity programs in schools, hc can advise physicians in practice about the facilities and personnel in schools that can help them carc effectively for their child patients.

Forces Affecting Program

Thc school health program is the resultant of many forces. One of these forces, which has been designed to do good but often becomes distorted or misdirected, is legislation. It is not uncommon for statutes to require annual physical examinations where there are insufficient physician man hours to care for the obviously ill, let alone the apparently well. Often this is flavored with enforced modesty in that the degree of undress is stipulated. This often is inadcquate for even a cursory examination. Generally better results occur when administrative regulation rather than legislative statute sets the detail of practice. It can be altered to meet a developing program.

Another significant force is the school administrator. Some few have a peculiar idea of the services the school should have from the physician, nurse, and other health service personnel. Wherever the administrator is informed on good school health practice and supports, through his budget and his administrative edicts, a well-rounded and adequate program coordinated with the health services of the community, the school physician can be truly effective.

The physicians practicing in the community and the local medical society are other factors influencing the school physician's program. If the profession is preventive minded and welcomes the opportunity to practice preventive medicine on child patients, the school physician will have time to do something besides routine appraisals. If the hospitals and out-patient services catering to the indigent and near-indigent will extend their services to include periodic appraisal as well as illness care, it will be possible to do effective education on how to utilize available medical services. But where physicians and hospitals are too pressed for time to counsel the

[5]Bonvechio, L. R. and Dukelow, D. A.; "Responsibilities of School Physicians," *Journal of School Health*, 31:21 (June 1961)

well and too uninformed to be interested in preventive practice, the school physician often must modify his program to do many of the things that should be done by physicians in clinical practice.

The medical society often can help give social acceptability to professionally sound school health policy and practice. It may take the patience of Job to get a committee opinion in the first place and years of education to have it endorsed by the society, but it can be done. When it is an accomplished fact, it becomes the policy of the medical society and serves as a tool for further in-service education of physicians handling children in clinical practice. In time this group will be sufficiently convinced of the desirability of good school health practice to influence legislation, or at least to get administrative or board regulations to guide the program.

Sooner or later the parents and families of these children get into the act. For the past seven years the National Congress of Parents and Teachers has promoted a program for continuous health supervision from birth through the school years[6] which was promulgated by a medical advisory committee under the late Dr. Henry Helmholz. This encourages examinations by the child's personal physician wherever possible. Since it is an extension of the "Summer Round-Up" well known to parents and teachers since 1925, the PTA program can be a force favorably affecting the entire program of school health.

New Jersey Specifics

While preparing for this meeting, I encountered, among many articles, three significant documents. One was the School Laws and State Board of Education Rules and Regulations for Health[7] and the supporting documents supplied by Doctor Esty.† The others were articles published in the JOURNAL of the Medical Society of New Jersey by Kuvin and Kuvin[8] in 1961, and by Hudson and Levitas[9] in 1962.

First, the law. It is my impression that in New Jersey a physician must be employed by *every* board of education as a medical inspector. The medical inspector is required to "lecture before teachers" on the technics of teacher observation; to explain to school personnel the rules and practices adopted by boards of education to govern various personal and environmental health conditions; prescribe first aid equipment and supplies; "examine every pupil to learn whether any physical defect exists"; notify parents of proposed examinations; examine candidates for school athletic teams prior to the first practice session; recommend regarding exclusion and readmission of pupils; direct the professional duties and activities of school nurses; comply with health department rules and regulations; accept the record of a medical examination by the child's physician; and inspect school kitchens and lunch rooms.

The standards developed under the law expand the details of practice. For example, physical examinations of pupils are to be performed annually *where feasible* and as early in the school year *as possible*. The school physician examines pupils referred for special health problems, to determine fitness for physical education or unfitness to receive vaccination. He examines new entrants, the physically handicapped, referrals for psychiatric consultation, those with suspected communicable disease, those needing first aid, and candidates for sports programs and varsity games. The detail of examination is so complete it suggests that the physician doesn't know how to make one.

In addition, the medical inspector performs appraisal examinations of school employees, persons seeking working papers, and in his spare

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[6]Mitchell, H. H. Peeples, W. J.; "Progress Toward Continuous Health Supervision," *American Journal of Public Health,* 51:1853 (December 1961).

[7]School Laws and State Board of Education Regulations for Health Division of Curriculum and Instruction. State of New Jersey Department of Education, Trenton 25, New Jersey. Revised September, 1962. Also: Recommendations for Pupil Health Examination. Memorandum from Dr. Everett L. Hebel, Director, Office of Health, Safety, and Physical Education, State of New Jersey Department of Education, Trenton 25, New Jersey; and Recommended Standards Governing the Duties of the School Physician. Division of Curriculum and Instruction, State of New Jersey Department of Education, Trenton 25, New Jersey. August 1962.

†Geoffrey W. Esty, M.D., is Special Consultant in School Health, New Jersey State Department of Education.

time supervises the nurse and interprets the school's health policies to everyone including other physicians.

This is essentially a good program, though it is "hide-bound" by being frozen into statute for the larger part.

In your JOURNAL, Doctors Kuvin and Kuvin[8] reported on the school physician's role. In summary they said, "It was determined that the school physician's abilities are not fully utilized because of the pressure due to 'routine' but inefficient physical examinations. Corrective legislation is needed to help the school physician in his educational and advisory tasks."

A year later Doctors Hudson and Levitas reported their experience in Bergen County in your own JOURNAL[9]. I suggest that you reread this article with your own school district in mind.

A reasonable program *can be* conducted in spite of a restrictive law if one visualizes a child centered program based on sound interprofessional relations. I grant the law could be bettered, but it is not a complete barrier to progress. It may be changed if your legislators know what is needed to produce effective efficient practice.

Summary

The school physician is an administrator, an educator, a specialist in fitness; a liaison between the school, the practicing professions, and the families of his children. Oriented in the prevention of illness and the promotion of health his major responsibility should be as medical advisor to the school, a consultant in health education, an administrator of far reaching programs of child health. To burden him with endless routine physical examinations deprives the school and the community of the services he alone can perform as a medical interpreter.

All recognized authorities agree essentially on the role the school physician should perform. For one reason or another, comparatively few are free enough from routine to reach the attainable heights of good school health practice. However, when the community of parents and the practitioners of medicine and of education feel strongly enough about the nature of the school health program they want, means for implementing it can be found.

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[8]Kuvin, S. F., and Kuvin, J. S.: "The School Physician's Role in New Jersey," JOURNAL of the Medical Society of New Jersey, 58:218 (May 1961).

[9]Hudson. Phoebe, and Levitas, Irving M.: "A New School Health Program in Practice," JOURNAL of the Medical Society of New Jersey, 59:246 (May 1962).

535 North Dearborn Street

No Aspirin for These Headaches

Nearly all pharmaceutical companies report that their costs have sky-rocketed. Most of the additional expense is in research, packaging, labeling, advertising, and in meeting foreign competition. One company estimates an increase of seven per cent in research costs, *due exclusively to additional paperwork*. Another states it will have to destroy $85,000 in noncomplying packaging materials despite every effort to anticipate the regulations and minimize losses. One company had to reprint inserts for and repackage 450,000 items already in inventory or actually distributed when the change demanded was minor, of questionable validity, and could just as well have been made effective with new production. Because of the amount of information now required in advertisements, many companies fear they must now purchase multiple section ads where before smaller ads were sufficient, or give up some of their advertising. The requirement that the generic name be used every time the trade-mark is mentioned is cumbersome. Only time will reveal how costly and grotesque in appearance this type of display may prove to be.—Austin Smith, M.D., President, Pharmaceutical Manufacturers Association, to Federal Bar Association meeting, Washington, D. C., June 27, 1963.

This year marks the 400th anniversary of the birth of William Shakespeare. So Dr. Friedenberg's historical vignette is appropriate.

Did Shakespeare Describe Angina Pectoris?

Sidney Friedenberg, M.D./Camden

For the first description of angina pectoris, credit is usually given to William Heberden the elder (1710-1801) although the memoirs of the Earl of Clarendon (1632) contain a description of the symptoms. William Shakespeare (1564-1616) antedates them both. Since he was a playwright and not an essayist, he wrote with the visual image and impact of speech in mind. His image of an old man with angina pectoris was so intense that, once seen, it can never be forgotten. I refer to "The Tragedy of King Lear" (1608).

The plot of "King Lear" is simple: an old man, he divides his lands between his two older daughters. He disinherits his youngest, Cordelia, because—caught up in flattery—he misunderstands a speech of sincerity and true love. The king, now an outcast from one daughter, has an inkling of his reception from the other.

Here, then, he must clutch his mid-breast and cry out, "O, how this mother swells toward my heart! *Hysterica passio!* down, thy climbing sorrow! Thy element's below."

Twice more in the play he refers directly to his heart and he dies suddenly. Surely, an autopsy of King Lear would have shown "pipe-stem" coronary arteries and possibly an early cardiac infarct.

Shakespeare was describing a clinico-pathological event for which, at that time, there was no medical term, but it is obvious he recognized the significance of the symptoms, almost eighty years before Heberden.

In different ages, words lose their old connotations and gain new ones. Diagnoses once considered correct are now known to be inaccurate or false. Even printers can err. Did Shakespeare write "how this mother swells toward my heart!" or "how the smother swells toward my heart!" "Mother" was a term well-known by physicians of his day and was associated with hysteria, but "smothering sensation" described to a modern physician must make him include angina pectoris in his differential diagnosis. One early edition of "King Lear" actually did have the spelling "smother."

Hysterica passio was in the common jargon of physicians of the sixteenth century. There are various interpretations. One is that it was globus hystericus, a *smothering* sensation associated with pregnancy.

It seems, therefore, that Shakespeare recognized angina pectoris and its ultimately fatal outcome. He did not originate the name, but why should he? He had no more reason to coin medical terms than to invite physicians to become playwrights.

2990 Alabama Road

STATE ACTIVITIES

Our Judicial Mechanism*

The statewide judicial mechanism as such was called into being by our House of Delegates in May 1950. For thirteen years the efforts of a succession of dedicated members and staff personnel have been directed to the purpose of producing a sound and dependable *modus operandi.*

This mechanism is intended, we are told, "to improve public and intra-society relations by making available a means whereby differences and disagreements in the areas of ethical and professional conduct can be brought informally to a settlement that is fair to the interests of all parties."

Two elements of that declared purpose deserve special emphasis. First, the mechanism—confidential in its essential character—is to be operated *"informally."* That means that we physicians who sit on judicial committees and councils do not presume to be self-appointed lawyers or judges. In our own persons and characters, with no wrappings or trappings of legal language or legal technics, we address ourselves to the task of finding where truth and fairness lie. We ask questions as we need to. We do not restrict ourselves or those before us to the rigidities of court-room practices. We appreciate that in good faith matters at issue have been submitted to us for settlement. We do our best—as ourselves—to evolve the fair findings that will effect such settlement.

There is another reason for avoiding the formalities of court-room proccdures—apart from our own lack of command of those procedures—and that is that we invite as proper to our function only matters involving alleged violation of principles of ethical conduct or standards of professional behavior.

Matters of law we leave to the courts. We have neither the desire nor the intent to infringe upon the considerations of law or the functions of the courts. We prefer "to render to Caesar the things that are Caesar's." In turn, we offer ourselves as ready to deal with things of ethical and professional character that do not involve civil laws or their transgression, but *do* involve the ethical and professional standards of good medical practice.

The second element of the declared purpose of the mechanism is that the settlements sought and arrived at must be "fair to the interests of all parties."

Complete impartiality must prevail. In good faith the parties in disagreement submit the matter in dispute to the judicial mechanism for settlement. In good faith we deal with it, guided by the facts as we discover them and the canons of ethical and professional conduct as we know them. Findings arrived at in this spirit and by these means will not, of course, always be satisfactory to the parties involved; but they should be unimpeachably and demonstrably impartial and fairly based on the evidence presented. They should show to members and non-

* Remarks of E. Vernon Davis, M.D., Chairman, Judicial Council, delivered at the Judicial Conference on Sunday, November 3, 1963.

members alike that "medicine can equitably and amicably settle its own problems in the areas of ethical and professional conduct."

It is, I think it will be freely conceded, a proper and necessary service to our member-physicians that we make available to them a mechanism—of acknowledged authority, integrity, and competence—to deal with complaints brought against them by fellow-physicians or by patients. The person who is in the right is vindicated and his reputation cleared of the shadow which the complaint cast upon it. The person who is in the wrong is so informed and given the reasons why; so that, in justice, he may intelligently cooperate in achieving the necessary readjustments.

Matters involving violations of civil law are beyond the scope of our mechanism. "Indeed," the Foreword to the *Regulations* declares, "only when all principals to a complaint agree to submit the matter of the complaint to our judicial mechanism, and give assurance that no court action is pending or contemplated, should the matter be accepted for processing."

This is to insure that no one of the parties to the complaint views the matter at issue as having any bearing on civil law, or in any regard, proper to the jurisdiction of the courts. It is to insure that the parties to the complaint recognize it as involving not legal considerations, but considerations in the realm of ethical and professional conduct, and therefore proper to the scope of the judicial mechanism, to which they freely submit it.

No one who has for any appreciable length of time served on the Judicial Council or on a county judicial committee can fail to perceive that a great proportion of complaints arise not so much from serious and blame-worthy violations of the Principles of Medical Ethics as from either a conflict of personalities, or ignorance of, or indifference to, the exactions imposed by good manners.

The age in which we live is, among other things, marked by a decline in the popular regard for and indulgence in the "good manners" that were so emphasized by "people of breeding" in other, earlier times. Good manners and refined considerateness, not only of the rights but of the sensibilities of others, are still a splendid and necessary lubricant for the machinery of the life of society. If the doctor-patient relationship were not only intimate but mannerly, the judicial mechanism would be called upon to deal with far fewer complaints. If justice and good-taste were constantly and equally observed by physicians and patients alike, there would be a sharply diminished need for a judicial mechanism at all. But, human nature being what it is, personalities and characters widely diversified as they are, and aggressive self-interest flourishing as it does, we have a job to do that will probably engage us for many, long years.

Some time ago, the Council on Public Relations of The Medical Society of New Jersey issued to us as members advice for good public relations, to encourage and assist us in our efforts to do justice to ourselves, to our profession, and to our patients. I should like to quote some of the recommendations of the Council on Public Relations as embodying what the Judicial Council considers good advice for avoiding such poor doctor-patient relations as lead to the submission of complaints to the judicial mechanism:

DO . . . remember always that nothing but your best—in service and in courtesy—is permissible or acceptable.

DO . . . be considerate of each patient's point of view and of each patient's problems; he looks to you to be a friend in need.

DO . . . be tolerant toward others including your colleagues, but exacting toward yourself.

DO . . . take the time to explain procedures and to discuss costs with your patients.

DO . . . expect proper compensation for your professional services but be disposed generously to give *yourself* away.

DO . . . be at pains never to be so busy as to lack time to do the considerate little things that prove how big you really are.

DON'T . . . be late for appointments; regard your patient's time as of equal value with your own.

DON'T . . . leave your practice uncovered; arrange with a dependable colleague to take care of calls received in your absence.

DON'T . . . be easily annoyed; if you are, it means that your head is bigger than your heart.

DON'T . . . be afraid to be friendly; only the consciously inadequate erect protective barriers of aloofness.

DON'T . . . be indecisive or vacillating; your patient's confidence in you will be in direct proportion to your decisiveness and definiteness.

I should like to add one further "don't":

DON'T . . . indulge gratuitously in disparaging criticism of another physician's treatment of his patient or patients. Such comments are frequently motivated more by self-interest than by concern for the patient's well being and for the most part they are of no measurable advantage to any one.

I think we have been doing a good job, but we must strive, at all levels of the free practice of medicine, to do a still better one. In fact we must prove—by the way in which we care for and satisfy the needs of our patients—that the personalized, dependable, and successful professional services rendered under a free-enterprise system of medical care are the best that can be devised.

If we do not succeed in this, we may not find ourselves functioning as significant parts of a judicial mechanism but as insignificant parts of a regimented federal mechanism that debases not only the standards of medical care but the dignity, freedom, and satisfaction of doctors and patients alike.

Academy of Medicine Library: New Acquisitions

The Library of the Academy of Medicine of New Jersey, 307-17 Belleville Avenue, Bloomfield, N. J., announces the following new acquisitions:

Biochemistry:

Hofmann, K. Fatty acid metabolism in microorganisms. New York, Wiley, 1963. (E. R. Squibb Lectures on Chemistry of Microbial Products.)

Cancer:

Advances in cancer research, vol. 7. New York, Academic Press, 1963. *Also:* Brecher, R. and Brecher, E. Consumer's Union report on smoking and the public interest. Mount Vernon, N. Y., Consumers Union, 1963 (Paperbound). *Also:* U. S. National Cancer Inst. Symposium; analysis of carcinogenic air pollutants. Wash., D. C., G.P.O., 1963.

Genetics:

Sturtevant, A. H. and Beadle, G. W. An introduction to genetics. New York, Dover, 1962.

Internal Medicine:

Blaustein, A. The spleen, New York. Blakiston, McGraw Hill, 1962. *Also:* Beeson, P. B. and McDermott, W., ed. Cecil-Loeb Textbook of medicine. 11th ed. Philadelphia, Saunders, 1963. *Also:* Likoff, W. and Moyer, J. H., ed. Coronary heart disease; the seventh Hahnemann symposium. New York, Grune and Stratton, 1963. *Also:* Russell, P. F., West, L. S., Maxwell, R. D. and McDonald, G. Practical malariology. 2nd ed. London, Oxford Univ. Press, 1963.

Medical Jurisprudence:

Cusumano, C. L. Malpractice law dissected for quick grasping. New York, Medicine-Law Press, 1962. *Also:* Hazards of the road. Special issue of: "Medicine, Science and The Law," vol. 3 (1): Oct. 1962.

Medical Writing:

Thomas, P. A guide for authors; manuscript, proof and illustration. Springfield, Ill., Thomas, 1962. *Also:* American Dental Assoc. Council on Journalism and American Assoc. of Dental Editors. Conference on dental journalism, Mar. 13-14, 1961, Chicago, Ill.

Ophthalmology:

Ellis, P. P. and Smith, D. L. Handbook of ocular therapeutics and pharmacology. St. Louis, Mosby, 1963.

Otorhinolaryngology:

Ryan, R. E., Thornell, W. C. and von Leden, H. Synopsis of ear, nose, and throat disease. 2nd ed. St. Louis, Mosby, 1963.

Pediatrics:

De Sanctis, A. G. and Varga, C. Handbook of pediatric medical emergencies. 3rd ed. St. Louis, Mosby, 1963. *Also:* Holt, L. E., McIntish, R. and Barnett, H. L. Pediatrics. 13th ed. New York, Appleton-Century-Crofts, 1962.

Pharmacology and Toxicology:

Frear, D. E., comp. Pesticide handbook. 15th ed. State College, Penna., College Science, 1963. *Also:* Lucia, S. P. A history of wine as therapy. Philadelphia, Lippincott, 1963.

Psychiatry and Psychology:

American Psychiatric Assoc. Bibliography of child psychiatry, with a selected list of films, by I. N. Berlin. Wash., D. C., A.P.A., 1963. *Also:* Fodor, N. and Gaynor, F., ed. Freud; dictionary of psychoanalysis. New York, Premier, 1958. *Also:* Morgan, C. T. Introduction to psychology. 2nd ed. New York, McGraw-Hill, 1961. *Also:* New York (State) Psychiatric Inst. Dept. of Medical Genetics. List of departmental publications and dissertations (1938-61). (Mimeographed) *Also:* Osgood, C. E. and Miron, M. S., ed. Approaches to the study of aphasia. Urbana, Ill., Univ. of Illinois Press, 1963. *Also:* U. S. National Institutes of Health. The role of speech in the regulation of normal and abnormal behavior; four papers. Bethesda, Md., 1960. *Also:* Wortis, J., ed. Recent advances in biological psychiatry, vol. 5. New York, Plenum Press, 1963.

Public Health:

Dunning, J. M. Principles of dental public health. Cambridge, Mass., Harvard Univ. Press, 1962. *Also:* Rozenfel'd, I. I. Curative and preventive aspects of public health services for rural population, transl. from Russian. Wash., D. C., Israel Program for Scientific Translations, 1963.

Radiology:

Dewing, S. B. Modern radiology in historical perspective. Springfield, Ill., Thomas, 1962.

Reference Books and Miscellaneous:

Flippin, H. F. Medical state board questions and answers. 10th ed. Philadelphia, Saunders, 1962. *Also:* Rypins' Medical licensure examinations; topical summaries and questions. 9th ed. Philadelphia, Lippincott, 1960. *Also:* Gage-Babcock, Inc. Protecting the library and its resources. Chicago, American Library Assoc., Library Technology Project, 1963. *Also:* Robins, R. B., ed. The environment of medical practice; socioeconomic and ethical phases of medicine for those in medicine or embarking on a medical career. Chicago, Year Book Publishers, 1963. *Also:* U. S. Dept. of Health, Education and Welfare. Career opportunities in the Public Health Service, Bureau of Medical Services, 1963. Wash., D. C., G.P.O., 1963. *Also:* U. S. Dept. of Health, Education and Welfare. A survey of research on reproduction related to birth and population control (as of December 1962). Wash., D. C., 1963. *Also:* Winchell, C. Guide to reference books. 4th Suppl., 1959-62. Chicago, American Library Assoc., 1963.

Surgery:

Demikhow, V. P. Experimental transplantation of vital organs, transl. by B. Haigh. New York, Consultants Bureau, 1962. *Also:* Hershey, F. B. and Calman, C. H. Atlas of vascular surgery. St. Louis, Mosby, 1963. *Also:* Lahey Clinic. Surgical practice. *Also:* Shields, J. R. Handbook of the practice of anesthesia. Saint Louis, Mosby, 1963.

To Wrap or Not To Wrap

The February and March issues of THE JOURNAL will be mailed without the usual wrapper. This is being done on a pilot study basis. Your reaction is invited. Let us know if your JOURNAL arrives in good condition—and whether you approve this type of mailing.

With the expanded and modern facilities of our new printer, it is reported that THE JOURNAL can save about $1,800 a year if the wrapper is eliminated and a mailing label substituted. With the increasing costs of maintaining our JOURNAL, we have felt that such a savings was worth investigation.

To wrap or not to wrap . . . that is the question. You will make the final determination. Let's have your opinion—after you've received the February and March issues.

OBITUARIES

Dr. Anthony M. Arangio

At the early age of 52, a heart attack on November 18, 1963 took the life of Dr. Anthony M. Arangio, a member of our Middlesex County Medical Society. Born in Montreal, he received his M.D. at the University of Bologna in 1941. He did graduate work in psychiatry at the Trenton State Hospital here and at the Howard (Rhode Island) State Hospital. After a year at the Psychiatric Institute of the Pennsylvania Hospital, he went into practice at Edison, New Jersey, also serving as an attending psychiatrist at the New Jersey Diagnostic Center in Menlo Park. He was, in addition, a psychiatric consultant to the New Jersey prison system.

Dr. Ladislas Feher

One of New Brunswick's senior City Physicians died on October 21, 1963 after a long illness. Born in 1899, he received his M.D. at the Jefferson Medical College of Philadelphia in 1924. Dr. Feher was a general practitioner with special interest in obstetrics and gynecology. He was active in the affairs of the Middlesex County Medical Society. He was an attending obstetrician at St. Peter's Hospital and an attending gynecologic surgeon at Middlesex. Dr. Feher was a pioneer member of the New Jersey Obstetrical and Gynecologic Society, and from 1931 to 1961, he was a New Brunswick City Physician.

Dr. William Fessler

One of New Jersey's pioneer pediatricians, Dr. William Fessler died at the Englewood Hospital on November 13, 1963, at the age of 82. In 1907, he received his M.D. at the old Baltimore Medical College (now merged with the University of Maryland) and he interned in that year at the North Hudson Hospital in Weehawken. In 1918, he helped establish the pediatrics service at the Englewood Hospital, and became chief of that service soon thereafter. He also became affiliated with the Holy Name Hospital in Teaneck, becoming attending pediatrician there. In the early 1920's he was instrumental in establishing pediatric services and children's clinics in northern New Jersey and even in New York City—where he organized the pediatric service at the old German Dispensary on West 42nd Street.

Dr. Edward S. Krans

One of our Society's oldest practitioners, Dr. Edward Krans, died on August 12, 1963 in Florida where he was living in retirement. Dr. Krans was 85 years old at the time of his death. He received his medical degree in 1907 from Columbia University's College of Physicians and Surgeons. He entered the field of internal medicine after some years as a family practitioner. He served through all grades at Muhlenberg Hospital, eventually becoming Senior Attending Physician there. He retired in 1954. Dr. Krans was also on the Board of Managers at Glen Gardner and at Bonnie Burns.

Dr. William F. Matthews

Dr. William Frederick Matthews, former chief of staff at Mountainside Hospital, died there on November 15, 1963 at the age of 65. Dr. Matthews received his M.D. at the Medical College of Virginia in 1924. He interned for two years in New York City and came to Montclair in 1926. He devoted himself to pediatrics, and served in all grades on the pediatric staff of the Mountainside Hospital, becoming director of that department in 1950. Dr. Matthews also had several tours of duty on Montclair's Board of Health. In 1938 he was certified by the American Board of Pediatrics.

Dr. M. Frederick Ondovchak

After serving the people of Camden County for almost 40 years, Dr. M. Frederick Ondovchak died quietly in his sleep at his home in Mt. Ephraim on Columbus Day 1963. Dr. Ondovchak was born in 1898. He received his M.D. at Philadelphia Hahnemann in the class

of 1925; and after completing his internship, moved across the river to settle in Camden County. He was active in boro and civic affairs in Mt. Ephraim. Dr. Ondovchak was a general practitioner and proud to be called a family doctor. Until April 1963 he vigorously pursued his private practice, made his daily rounds. Then he was disabled by the illness which finally took his life.

Dr. Carl Rother

Born in Germany in 1885, Carl Rother received his M.D. degree at the Friedrich Wilhelm University in Silesia in 1911. He came to the United States in 1938, after a successful career as a gynecologist in Germany and Austria. He became affiliated with the North Hudson Hospital, and opened an office in Weehawken. At North Hudson he became an Associate Internist. He was also active in committee work for the Hudson County Medical Society. Dr. Rother died on October 1, 1963 at the age of 78.

Dr. William Schuchner

Dr. William Schuchner died on September 25, 1963 at the untimely age of 59. Born in Jersey City, Dr. Schuchner received his medical degree at Yale in 1929. A general practitioner, with a special interest in obstetrics, Dr. Schuchner served as adjunct in that specialty at the St. Francis Hospital in Jersey City. He was a member of the Hudson County Medical Society and had been since 1931.

Dr. Leslie R. Taber

Born in Syracuse, N. Y. in 1893, Dr. Leslie R. Taber died in the Valley Hospital in Ridgewood on October 21, 1963. After earning his baccalureate degree at Brown University, he went to the medical school of Cornell University where he received his M.D. in 1924. He came to Paterson to intern at the General Hospital there from 1924 to 1925, and remained in northern New Jersey for the rest of his life. Before going to medical school, he had served in the Ambulance Corps of the U. S. Army; and towards the end of the war, was accepted by the Lafayette Escadrille. He was a pioneer in military aviation, piloting planes as early as 1919 and 1920.

Dr. Taber was also an early worker in the field of radiology and cancer control. He was, by the time of his death, one of the senior members of the American Radium Society. Dr. Taber was a co-founder of Paterson's Lendrim Tumor Clinic. At the Paterson General, he served the Surgical Service in all grades, eventually becoming director of the Service.

Dr. James C. Tsucalas

Dr. James Christos Tsucalas, a prominent Hudson County general practitioner, died on September 15, 1963 at the age of 56. Born in upstate New York, Dr. Tsucalas received his medical degree at Georgetown in 1938. After doing general practice for a while, he applied for, and was granted, a commission in the medical corps of the United States Army. In 1946, he was demobilized and moved to Jersey City where he set up an office for general practice.

Dr. Edgar P. Weigel

A heart attack, incurred on November 2, 1963, while sitting in his car in a parking lot, took the life of Dr. Edgar Weigel, one of Union County's best known orthopedists. Born in Buffalo in 1900, he received his M.D. at the University there in 1924. He interned at Massachusetts General Hospital. Dr. Weigel was an attending orthopedic surgeon at both Alexian Brothers and St. Elizabeth's hospitals. Had he lived a few months more, he would have been installed this spring as secretary of the New Jersey Society of Surgeons. Dr. Weigel was known throughout the county as a rose fancier and an antique collector. The rose-bud in his lapel had become a personal trademark.

BOOK REVIEWS

Bedside Diagnosis. 6th Edition. By Charles Seward, M.D. Baltimore, 1962. Williams and Wilkins Company. Pp. 499 ($7.00)

This book on diagnosis—written particularly for the medical student and generalist—is delightful, interesting, and informative reading. The approach to diagnosis is by way of eliciting the significant symptoms and the systemic analysis of these. The book has some 26 chapters on such important symptoms as head pain, thoracic pain, various types of abdominal pain, cough epistaxis, hematuria, et cetera. One particularly interesting and significant chapter was *Drugs Considered as Causes of Symptoms.* In each chapter a synopsis of causes of the symptoms, physiology of the symptoms, the diagnostic approach, and the description of each cause or disease is made. The importance of the past history, habits, family history, social and emotional factors are discussed. The physical examination and other investigations required to complete the diagnosis are also included.

In general, this is the way most of us have been taught diagnosis; but the review in this book may be rewarding in many respects to the reader. I doubt if this is an extremely useful book to the internist, but it might serve as a quick, ready reference to keep at the bedside to confirm one's own thinking without the necessity of laboring over long treatises of medicine.

Jerome G. Kaufman, M.D.

Synopsis of Roentgen Signs. By Isadore Meschan, M.D. Philadelphia, 1962, Saunders. Pp. 436. Illustrated. ($11.00)

This compendium presents the author's systematic approach to diagnostic radiology contained in *Roentgen Signs in Clinical Diagnosis,* a text published in 1956 by Saunders. The current synopsis encompasses his three-phase curriculum for teaching radiology to medical students and graduate groups. The curriculum includes the diagramatic presentation of normal radiographic anatomy, presentation of roentgen signs which make up the basic concepts of roentgen pathology, and the organization of these criteria to reach a definitive diagnosis.

The outline follows the larger text but incorporates various study aids that will be particularly helpful to medical students. The anatomic diagrams and radiographic reproductions are well done and complement each other. Dr. Meschan's approach to diagnostic radiology is organized, concise, and well presented, and will be valuable to the medical student, general practitioner, or allied specialist.

John L. Olpp, M.D.

Dissemination of Cancer (Prevention and Therapy). By Warren H. Cole, M.D.; Gerald O. McDonald, M.D.; Stuart S. Roberts, M.D.; Harry W. Southwick, M.D. New York, 1961, Appleton-Century-Crofts, Inc. Pp. 462.

This remarkable volume is an extremely practical treatise, and it is interesting reading as well. Without deviating from a scholarly, precise, and well-documented presentation, the authors write in a style that is easy to read and understand. Portions of the work are almost as absorbing as a novel. Every aspect of dissemination of cancer is thoroughly presented from background and pathophysiology to clinical and research work in the field.

The most intriguing concept presented is that of intravasation of cancer cells, backed up with experimental and clinical proofs. This occurs when a vessel has been traumatized and when the surrounding tissue pressures are greater than the intravascular pressures, even momentarily. This evokes a sinister warning to the practitioner to avoid iatrogenic causes of possible metastasis. Examples of manipulations which can thus be implicated are palpation of the breast, dilatation and curettage, bimanual pelvic examination, transurethral resection, bone biopsy or curettage, skin preparation, operative retraction, manipulation, injection of fluid into tissues, and incisional and aspiration biopsy. All of these procedures have led to tumor cells

circulating in the blood of patients. Chemotherapeutic drugs are advocated to lessen their toll.

A list of practical measures presented for improvement of results in cancer therapy—in addition to early diagnosis, education, use of cytology, and precautions against manipulation —includes: destruction of ulcerating tumors, wound drapes, changes of instruments and gloves, wash basins containing special solutions, early operation after biopsy, wound irrigation with special solutions, measures to avoid implantation at anastomotic lines, gentle skin preparation, incisions adequate for tumor excision with minimal manipulation, no local anesthesia, gentleness in operating, ligation of vessels before handling organs, proximal tourniquets for extremity tumors, wide excisions, frozen sections for completeness of excision, excisions in continuity, avoidance of post operative stresses, adjuvants and prophylactic chemotherapeutic agents by perfusion and infusion.

Chapters are also devoted to the effects of stress, hormones, and immune responses on cancer dissemination.

While surgically oriented, this volume has great interest for all physicians dealing with cancer. Bertram Levinstone, M.D.

Surgical Practice of the Lahey Clinic. By Members of the Staff of the Lahey Clinic, Boston. Philadelphia, 1962. W. B. Saunders Company. Pp. 872. 628 illustrations on 387 figures. ($17.00)

This is the third edition of the Surgical Practice of the Lahey Clinic, the first appearing in 1941, the second 10 years later. This text follows its predecessor in being a most valuable reference and text. The procedures of the Clinic have been standardized and the results are reported from the most favorable procedures that they have used. Only the most favorable surgical procedures, as they have determined, are presented. Thus many extraneous and controversial procedures and ideas are eliminated; only the methods found to be most successful by the group are presented.

The format of this edition is somewhat different from that of its two previous publications. Not only the technics of the acceptable procedures of the clinic are presented, but some discussions of various subjects are also offered in papers prepared for publication by staff members.

The chapter on breast surgery, written by Cornelius E. Sedgwick, is most enjoyable, and the portion of this chapter on the cause and treatment of edema of the arm, following radical mastectomy by Magnus I. Smedal and James A. Evans, quite worthwhile. Included are reports on biliary tract surgery, most of which are contributed by William B. Cattell. This is a most complete and up-to-date discussion of the various types and conditions encountered in biliary disease. There are fifteen presentations in this area, all of which are commendable.

The text is 872 pages long, generously illustrated with 628 pictures, and easily readable. Its scientific style must be classed with the best.

That this text, presented at 10 year intervals, will remain a standard of reference there is little doubt. Daniel F. Featherston, M.D.

Activities of Medical Consultants. By W. Paul Havens, Jr., M.D. Washington, D. C., 1961, U. S. Government Printing Office. Pp. 880. ($7.50)

This is the first of three volumes covering the activities of consultants in internal medicine in the Army during World War II. It relates in great detail the organization and activities of this service in the various theaters of operations.

As the account unfolds, it soon becomes apparent that the functions of a medical consultant in the Army included not only clinical duties but involved much effort in problems of personnel, supply, and training as well as many various paramedical duties far removed from the bedside. Here the reader will find a complete and well-written account of the problems of internal medicine under diversified and difficult conditions.

This book should be of interest to anybody who was on duty in the medical department of the Army. It should be required reading for those concerned with organization of similar services in the future.

Gerald E. Muehsam, M.D.

ABSTRACTS

ON TUBERCULOSIS AND OTHER RESPIRATORY DISEASES. ISSUED BY THE NATIONAL TUBERCULOSIS ASSOCIATION

JANUARY, 1964 • VOL. XXXVII, NO. 1

EMPHYSEMA AND THE AGING LUNG

Study of the morphology, mechanics of breathing, and gas exchange of the lungs of aged people and comparison with the lungs of patients with obstructive emphysema leads to the conclusion that "senile emphysema" is not a disease entity.

To determine whether "senile emphysema" exists as a disease entity, a study was made of the pulmonary alterations associated with aging, and these were compared with the alterations described as "senile emphysema" and those in obstructive emphysema.

As for morphologic differences, the absence of significant airway obstruction in old persons is indicated at autopsy by the fact that their lungs will collapse readily, but the lungs of a patient with obstructive emphysema, where functionally significant airway obstruction is always present, do not collapse.

Furthermore, the pattern of the air spaces has not been found to be altered with age, but the normal pattern is disrupted in obstructive emphysema and lung tissue is destroyed. And there would seem to be no specific age changes in the structure of the lungs or thorax which could serve as the basis for a disease entity called "senile emphysema".

Respiratory Function Changes

As for alterations in pulmonary function with advancing age, there is an increasingly uneven distribution of both alveolar gas and pulmonary capillary blood flow with advancing age which results in less effective pulmonary function through two contrasting mechanisms. In some of the alveoli, ventilation is excessive in relation to blood flow and, thus, cannot be utilized; in others, ventilation is deficient in relation to blood flow so that oxygen uptake by the pulmonary capillary blood is not optimal. These changes are slight in normal aged persons and in those with barrel chest deformity. In obstructive emphysema, they are much greater and their effects are more serious.

MBC and Age

For many years the maximum breathing capacity (MBC) has been used to assess the bellows function of the lungs-thorax system. The relation of the MBC to age has been well established in large groups of subjects. It has been shown that the MBC rises rapidly from childhood to reach a peak at about age 20 and then declines in a relatively linear fashion with age. There is a more rapid decline with age in men than in women. The presence of barrel deformity of the chest is not associated with a further decrease in the MBC.

Because of criticism that the MBC test is too strenuous in severely incapacitated patients, several simple and less fatiguing tests have been introduced to provide equivalent information. All are based upon quantitative analysis of some portion of the maximal effort spirogram. One such test measures the flow rate of that portion of air expired from the first 200 ml. to 1,200 ml. of the forced expirogram. This is the maximal expiratory flow rate (MEFR).

The MEFR reaches a peak during the third decade and then declines in a linear fashion with age in men. The years treat women more

kindly than the men in respect to the MEFR, there being no significant change with age in women. By comparison, the MEFR is reduced in patients with obstructive emphysema, regardless of age.

Mechanics of Breathing

Although the changes in mechanics with aging might possibly be accounted for solely by alterations in the thoracic cage, recent studies of the mechanical properties of the lungs alone make this improbable. It has been demonstrated that with increasing age less intrapleural pressure is required to achieve a given degree of lung inflation. Age changes in the thoracic cage or its action are not solely responsible for the altered behavior of the mechanical properties of the respiratory apparatus. Important changes occur in the lungs themselves.

Airway resistance is always significantly elevated in obstructive emphysema and is probably the most important factor contributing to the decreased MBC and MEFR in this disease. Despite the intrinsic changes in the mechanical behavior of the lungs, airway resistance remains normal in the elderly.

Although a significant decrease has been reported with age in the maximal pulmonary diffusing capacity for oxygen in normal subjects, no correlation was found between the breath-holding pulmonary diffusing capacity for carbon monoxide and age. Since the diffusing capacity for oxygen is limited to some extent by pulmonary blood flow and the cardiac output decreases with age, an age correlation for this measurement is not surprising. However, the breath-holding diffusing capacity for carbon monoxide, which is not limited by blood flow, does not show an age correlation.

In patients with obstructive emphysema there is progressive decrease in pulmonary diffusing capacity with increasing severity of the desease, regardless of age.

Physiologic capacities deteriorate with age and the various aspects of lung function are no exception. It is not yet known whether senescence is the result primarily of genetically controlled involution or of repeated exposure to minor injuries, leaving a permanent mark.

Effect of Air Pollutants

Unlike other viscera, the lungs are continuously exposed to the injurious effects of the sea of polluted air in which so much of the world's population lives. Even though data are scarce, environmental effects on lung function must be differentiated from those of aging as such. Of the various environmental factors under investigation, other than industrial pollutants, cigarette smoking has been the one most implicated in the production of acute and chronic changes in lung function.

Although changes in lung function with age are qualitatively similar to the functional disturbances seen in the early stages of obstructive emphysema, the changes in obstructive emphysema are quantitatively more extreme. More significantly, the physiologic changes in obstructive emphysema are accompanied by dyspnea and the patient's exercise tolerance is limited by pulmonary disability.

Thus, neither a morphologic nor a physiologic basis exists for a disease entity called "senile emphysema."

Leon Cander, M.D.; William S. Blumenthal, M.D., Hahnemann Medical College, Philadelphia; *Geriatrics*, June, 1963.

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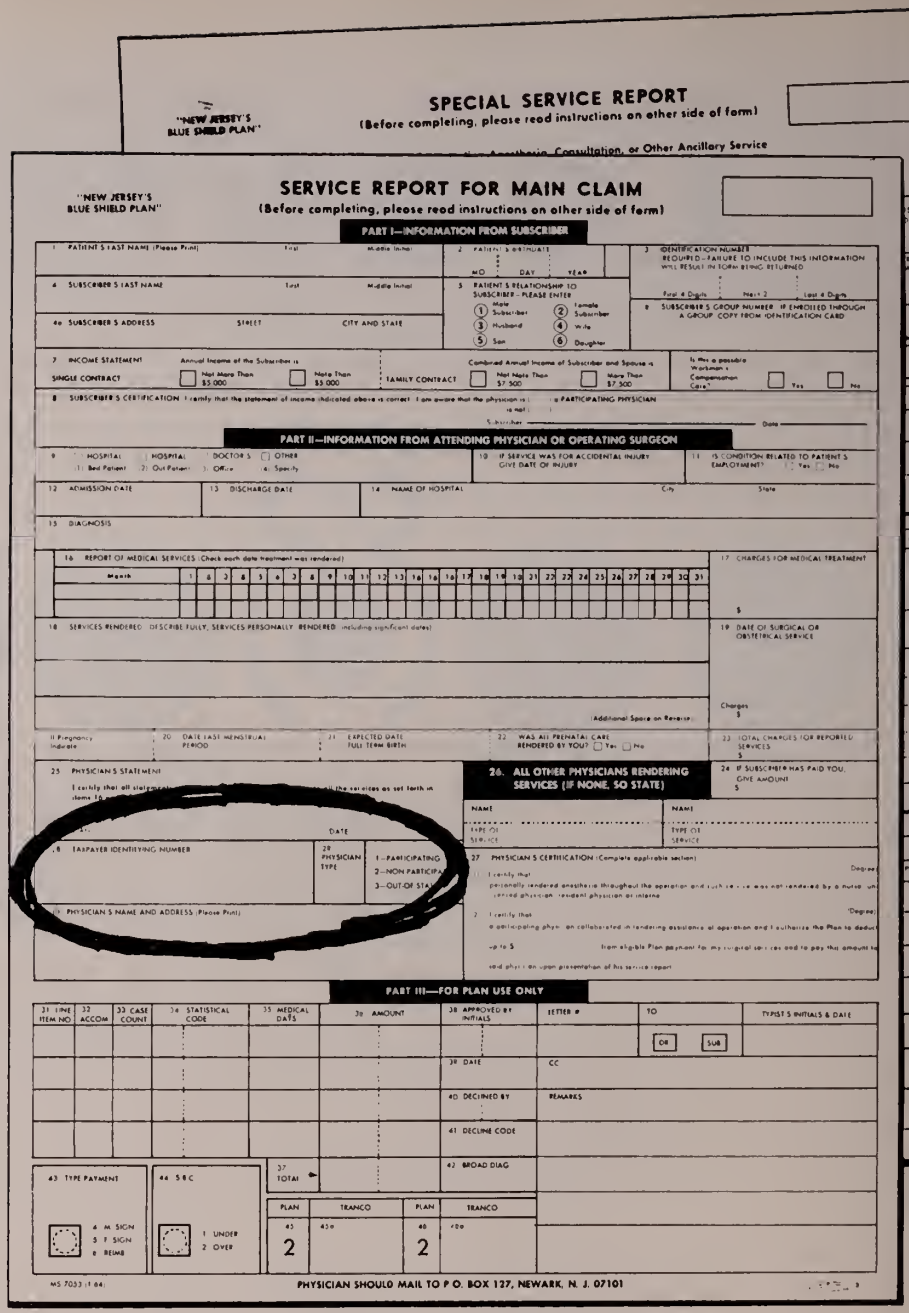
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2 PATIENT'S BIRTHDATE MO DAY YEAR

3 IDENTIFICATION NUMBER REQUIRED—FAILURE TO INCLUDE THIS INFORMATION WILL RESULT IN FORM BEING RETURNED First 4 Digits Next 2 Last 4 Digits

4 SUBSCRIBER'S LAST NAME First Middle Initial

5 PATIENT'S RELATIONSHIP TO SUBSCRIBER—PLEASE ENTER (1) Male Subscriber (2) Female Subscriber (3) Husband (4) Wife (5) Son (6) Daughter

8 SUBSCRIBER'S GROUP NUMBER IF EMBOSSED THROUGH A GROUP COPY FROM IDENTIFICATION CARD

4a SUBSCRIBER'S ADDRESS STREET CITY AND STATE

7 INCOME STATEMENT SINGLE CONTRACT Annual Income of the Subscriber is Not More Than $5,000 More Than $5,000 FAMILY CONTRACT Combined Annual Income of Subscriber and Spouse is Not More Than $7,500 More Than $7,500

Is this a possible Workman's Compensation Case? Yes No

8 SUBSCRIBER'S CERTIFICATION I certify that the statement of income indicated above is correct. I am aware that the physician is is not PARTICIPATING PHYSICIAN

Subscriber Date

PART II—INFORMATION FROM ATTENDING PHYSICIAN OR OPERATING SURGEON

9 HOSPITAL (1) Bed Patient (2) Out Patient HOSPITAL DOCTOR'S (1) Office OTHER (4) Specify

10 IF SERVICE WAS FOR ACCIDENTAL INJURY GIVE DATE OF INJURY

11 IS CONDITION RELATED TO PATIENT'S EMPLOYMENT? Yes No

12 ADMISSION DATE 13 DISCHARGE DATE 14 NAME OF HOSPITAL City State

15 DIAGNOSIS

16 REPORT OF MEDICAL SERVICES (Check each date treatment was rendered) Month 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

17 CHARGES FOR MEDICAL TREATMENT $

18 SERVICES RENDERED (DESCRIBE FULLY, SERVICES PERSONALLY RENDERED, including significant dates) Additional Space on Reverse

19 DATE OF SURGICAL OR OBSTETRICAL SERVICE Charges $

21 Pregnancy Indicate 20 DATE LAST MENSTRUAL PERIOD 21 EXPECTED DATE FULL TERM BIRTH 22 WAS ALL PRENATAL CARE RENDERED BY YOU? Yes No

23 TOTAL CHARGES FOR REPORTED SERVICES $

23 PHYSICIAN'S STATEMENT I certify that all statements ... the services as set forth in items 18 ... DATE

24 IF SUBSCRIBER HAS PAID YOU, GIVE AMOUNT $

26. ALL OTHER PHYSICIANS RENDERING SERVICES (IF NONE, SO STATE)

NAME TYPE OF SERVICE NAME TYPE OF SERVICE

28 TAXPAYER IDENTIFYING NUMBER 29 PHYSICIAN TYPE 1—PARTICIPATING 2—NON PARTICIPA... 3—OUT OF STA...

27 PHYSICIAN'S CERTIFICATION (Complete applicable section)

1 I certify that ... Degree personally rendered anesthesia throughout the operation and such service was not rendered by a nurse anesthetist physician resident physician or intern

2 I certify that ... Degree a participating physician collaborated in rendering assistance at operation and I authorize the Plan to deduct up to $ from eligible Plan payment for my surgical services and to pay this amount to said physician upon presentation of his service report

30 PHYSICIAN'S NAME AND ADDRESS (Please Print)

PART III—FOR PLAN USE ONLY

31 LINE ITEM NO	32 ACCOM	33 CASE COUNT	34 STATISTICAL CODE	35 MEDICAL DATS	36 AMOUNT	38 APPROVED BY INITIALS	LETTER #	TO DR SUB	TYPIST'S INITIALS & DATE
						39 DATE	CC		
						40 DECLINED BY	REMARKS		
						41 DECLINE CODE			
					37 TOTAL	42 BROAD DIAG			

43 TYPE PAYMENT 4 M. SIGN 5 F. SIGN 6 REIMB

44 S B C 1 UNDER 2 OVER

PLAN	TRANCO	PLAN	TRANCO
45 2	45a	46 2	46a

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*Schwartz, I. R.:
Current Therap. Res. 3:29, Feb., 1961

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Thursday, February 13th, 2:00 P.M. — Leukemia
Louis Wasserman, M.D., New York, Moderator

SECTIONS

PANEL DISCUSSION: GASTRIC FREEZING

Friday, February 14 - 9:30 A.M.
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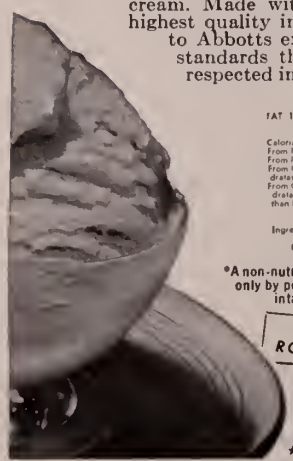
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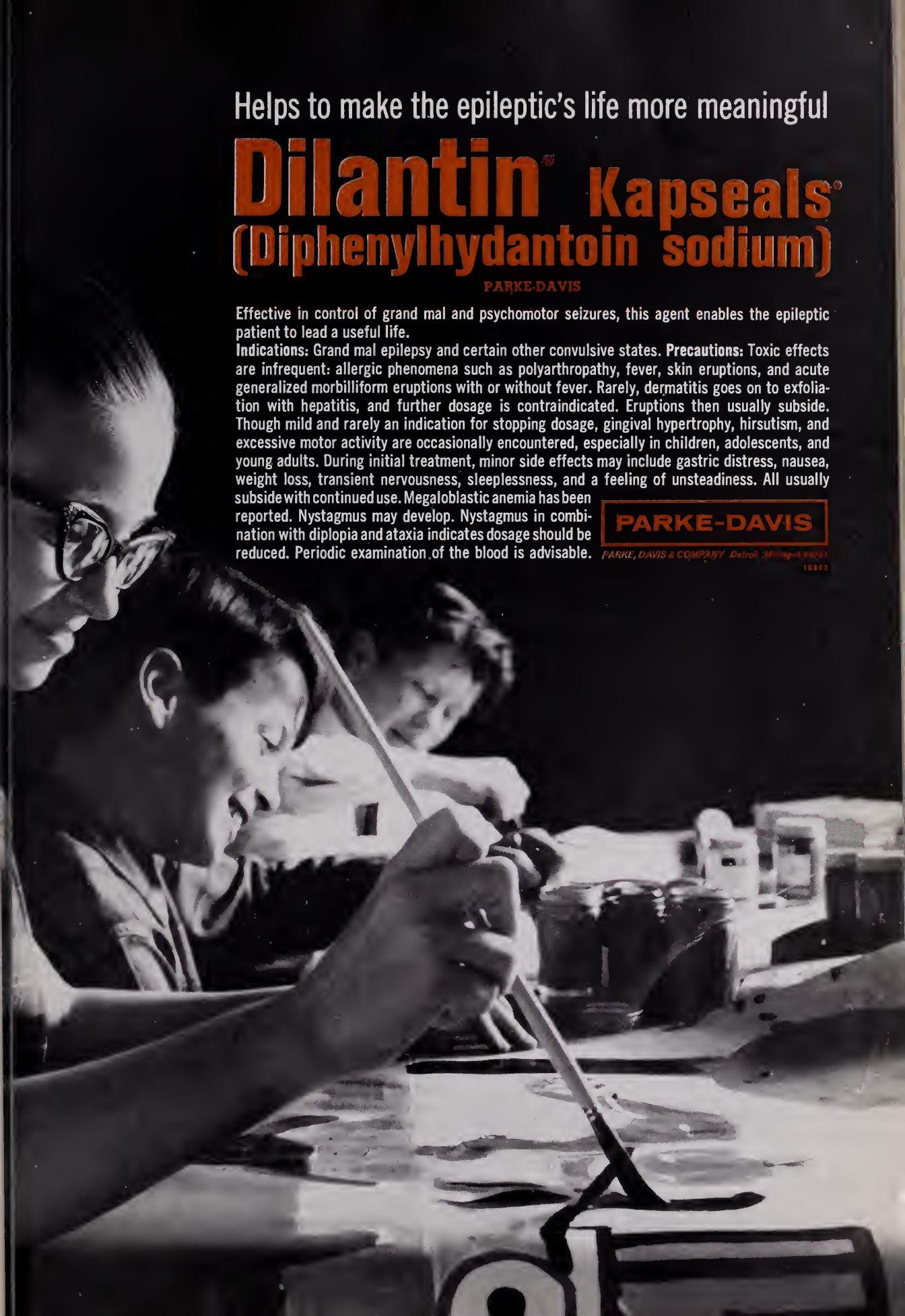
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THE JOURNAL
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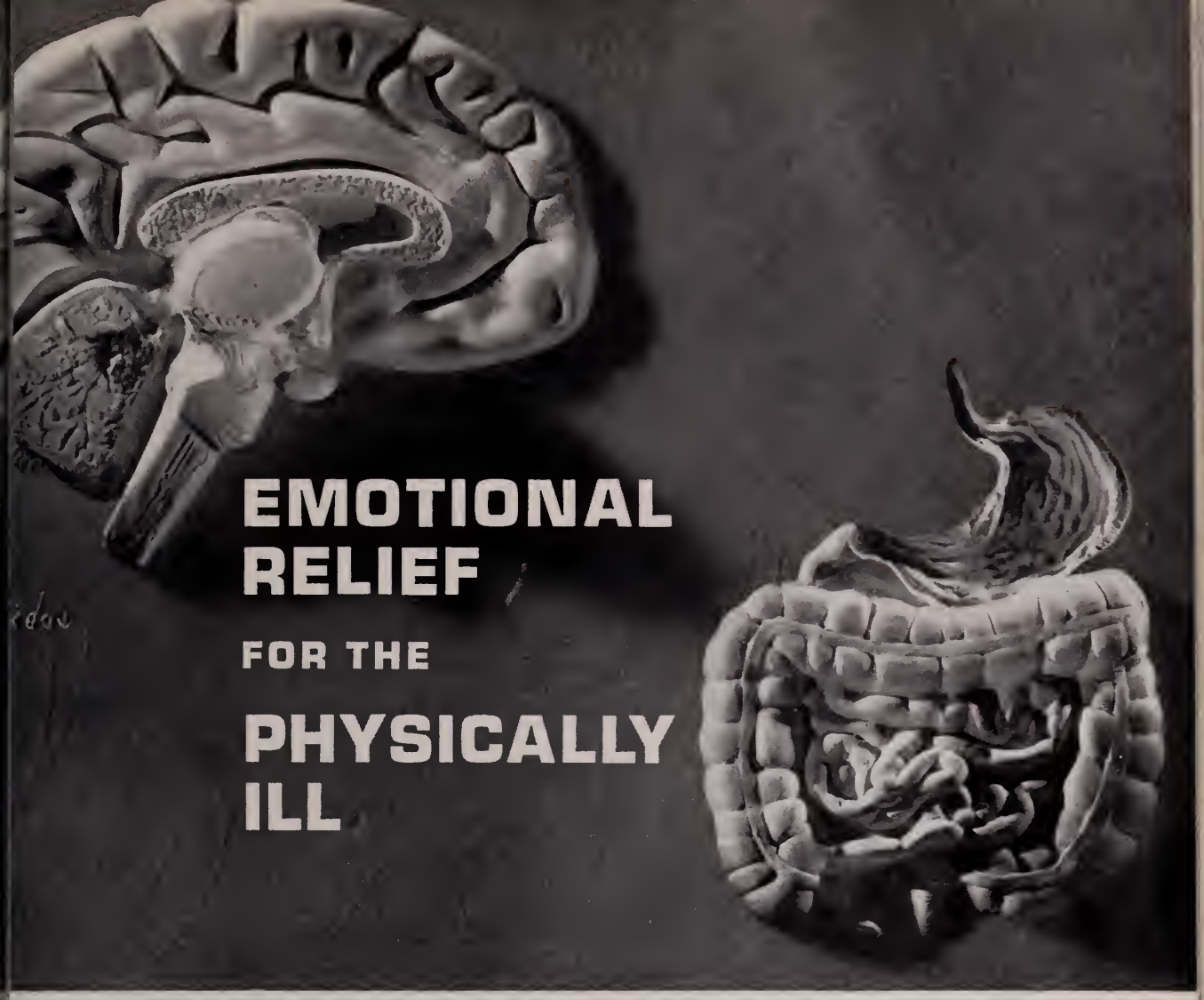
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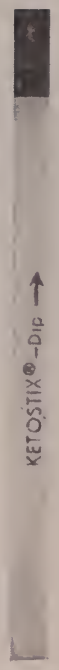
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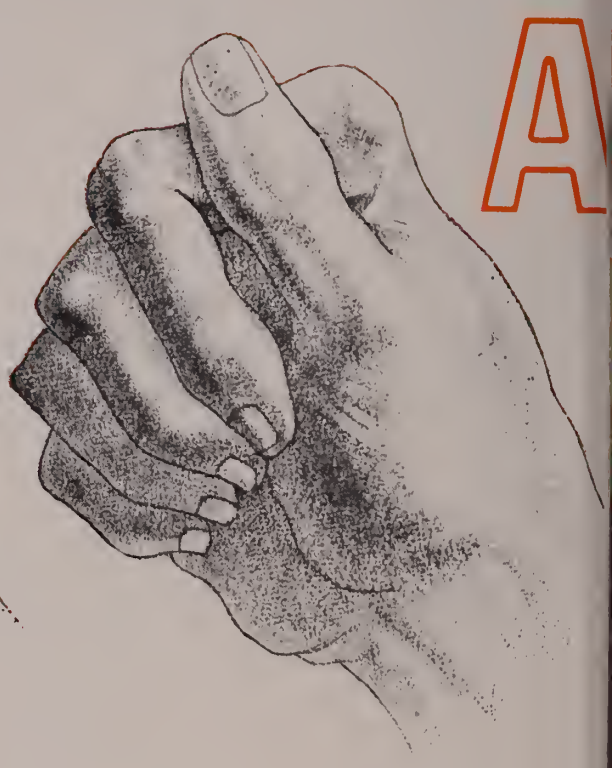
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* AMA Council on Foods and Nutrition: The Regulation of Dietary Fat, *JAMA* 181:411-423 (August 4, 1962).
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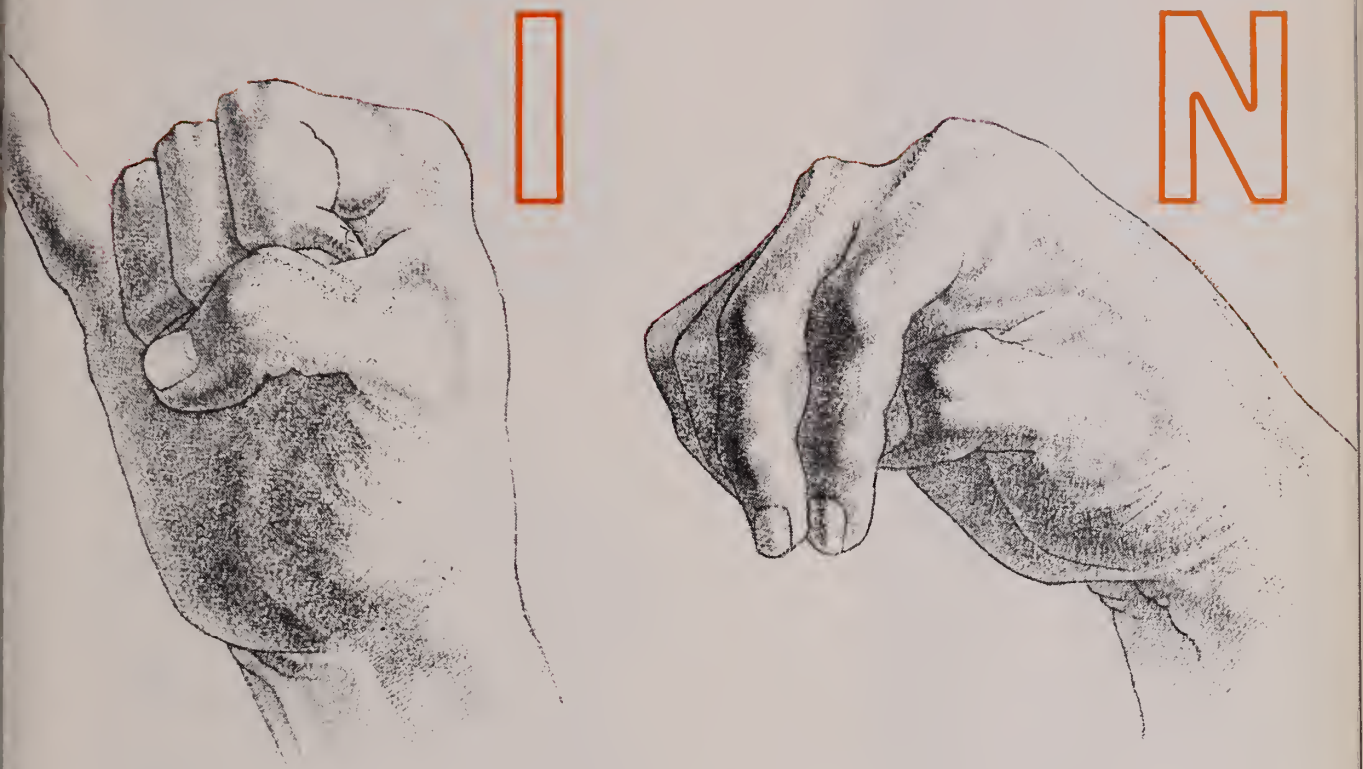
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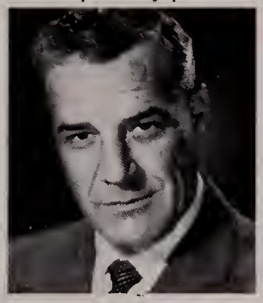
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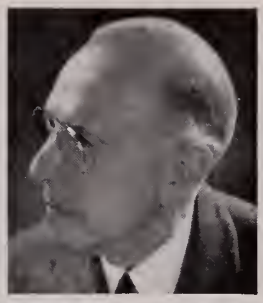
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But, from the equally important standpoint of the dollars-and-cents balance sheet, 1963 was a year to inspire sober thought among all who are interested in preserving the financial soundness of the "Blue" Plans.

When the final accounting is made, we believe the urgency of modernizing this approach to health care prepayment will become more apparent than ever. Such a program was advocated two years ago by Senator Dumont's bipartisan legislative commission, after three years of thorough study in the complex field of health care economics.

The Commission proposed legislation which would stabilize the financial base of Blue Cross and Blue Shield by encouraging good risks to remain with the Plans . . . more nearly balancing the financial loss entailed in the health care of the less fortunate who are historically the unique concern of Blue Cross and Blue Shield, among those agencies providing prepayment programs.

These bills, however, were not passed in the last two sessions of the Legislature.

This year, the program is being re-introduced in the State Senate, again under bipartisan sponsorship. It is essential, for the well-being of the 2½ million New Jerseyans now protected by Blue Cross and Blue Shield, that speedy action be taken.

The fulfillment of this program would assure continuing progress of the Plans and their ability to continue service to all risks, free of the inequities and frequent financial trauma which too often have hampered this pioneering approach to New Jersey's health care needs.

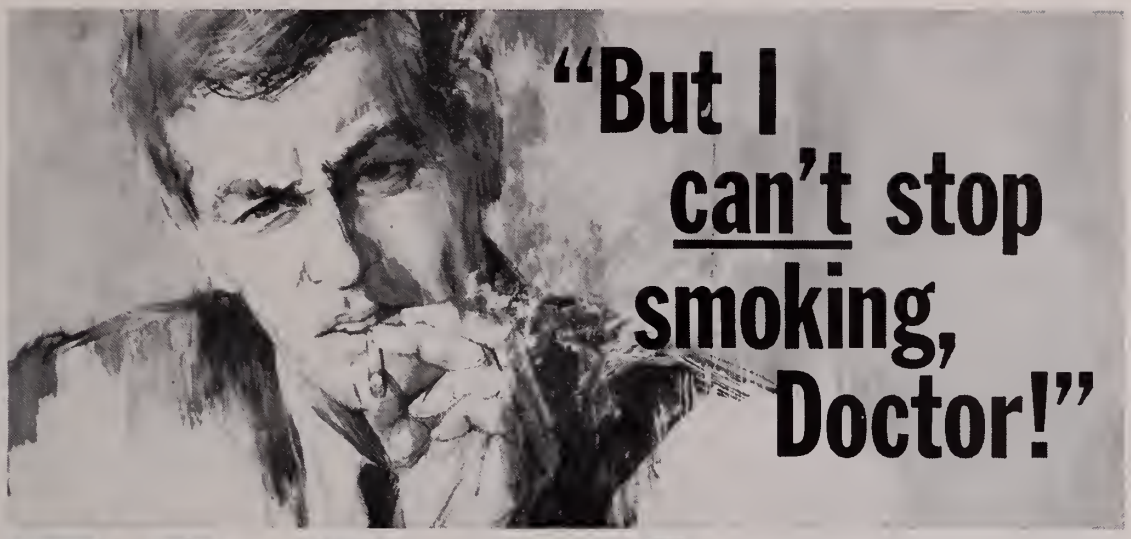
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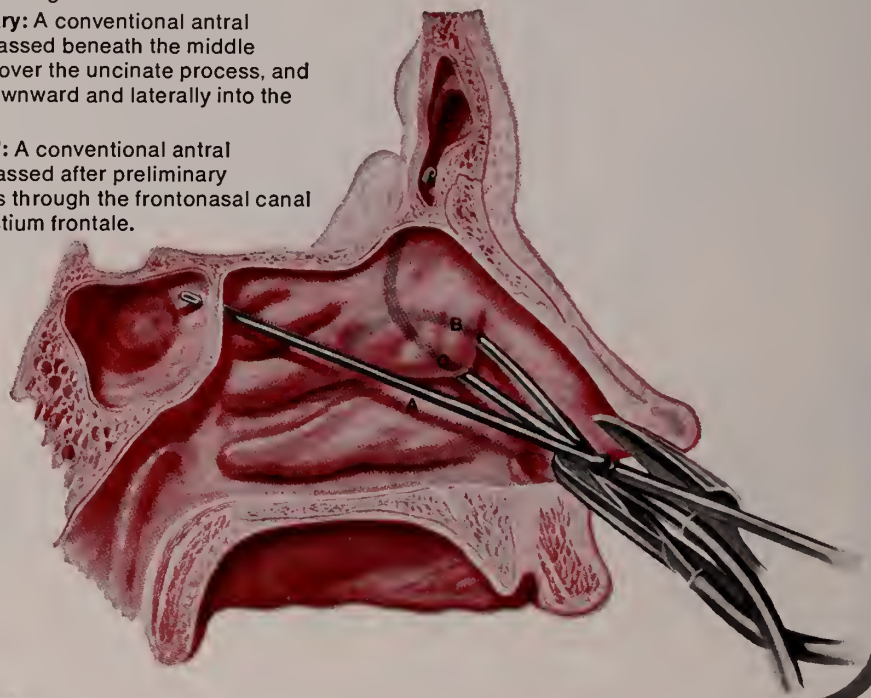
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*Reed, G. F.: Sinusitis, New England J. Med. 267:402, Aug. 23, 1962.

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who were the "untreatables"?

From their inception with cortisone, to the present-day variants of the steroid molecule, the corticosteroids have presented a therapeutic paradox. The beneficial action against inflammation and allergy as well as several undesirable metabolic effects are all, apparently, the results of the same basic physiologic action.[1]

Some of these associated metabolic reactions made it risky or otherwise undesirable to treat with steroids large numbers of patients in various categories who would otherwise have benefited from such management. These "untreatables" were overweight, had cardiac disease, hypertension, or pulmonary fibrosis associated with congestive heart failure. Also in this category were those patients whose emotional symptoms were aggravated by earlier steroids.

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While no steroid can *cure* a susceptible disorder, many patients who would otherwise be confined in a state of invalidism have, on ARISTOCORT® Triamcinolone, been able to pursue active, useful lives.

References: 1. Levine, R.: Rationale for the Use of Adrenal Steroids, Paper presented at Annual Convention, Medical Society of the State of New York, New York, May 13-17, 1963. 2. Hollander, J. L.: Clinical Use of Dexamethasone. *JAMA 172*:306 (Jan. 23) 1960. 3. Boland, E. W.: Chemically Modified Adrenocortical Steroids. *JAMA 174*:835 (Oct. 15) 1960. 4. McGavack, T. H.: The Newer Synthetic Adrenocortical Steroids in Therapy. *Nebraska Med. J. 44*:377 (Aug.) 1959. 5. Freyberg, R. H.: Berntsen, C. A., Jr., and Hellman, L.: Further Experiences with Δ1, 9 Alpha Fluoro, 16 Alpha Hydroxyhydrocortisone (Triamcinolone) in Treatment of Patients with Rheumatoid Arthritis. *Arthritis Rheum. 1*:215 (June) 1958. 6. Cahn, M. M. and Levy, E. J.: Triamcinolone in the Treatment of Dermatoses. *Amer. Practit. 10*:993 (June) 1959. 7. AMA Council on Drugs: New and Nonofficial Drugs. *JAMA 169*:255 (Jan. 17) 1959. 8. McGavack, T. H.; Kao, K.-Y. T.; Leake, D. A.; Bauer, H. G., and Berger, H. E.: Clinical Experiences with Triamcinolone in Elderly Men. *Amer. J. Med. Sci. 236*:720 (Dec.) 1958. 9. Fernandez-Herlihy, L.: III. Use and Abuse of Corticosteroid Therapy—The Structure and Biologic Activity of the Corticosteroid Hormones and ACTH, *Med. Clin. N. Amer. 44*:509 (Mar.) 1960. 10. McGavack, T. H.: Triamcinolone: A Potent Anti-inflammatory Sodium Excreting Adrenosteroid. *Clin. Med. 6*:997 (June) 1959.

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REFERENCES: 1. Goodman, L.S. and Gilman, A.: The Pharmacological Basis of Therapeutics, 2nd Ed., Macmillan & Co., New York, 1955. 2. Roberts, E.: Four Year Evaluation of an Antihypertensive Agent, J.A.M. Women's Assn. *13*:349, 1958.

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EDITORIALS

The Doctor's Own Society

The modern physician is an organization man. Usually he belongs to the triple-echelonned "official" society: county, state, and AMA. In addition, he generally pays dues to one or more hospital staffs or clinical societies; to two or more specialty societies or GP groups; to various lay health associations and civic organizations. While all this may make a satisfactorily large deduction every April, it also means that the practitioner would soon be entangled in a jungle of meetings if he didn't draw the line somewhere.

It is too bad that the line is so often drawn at the county medical society. Elsewhere in this JOURNAL (page 77) we publish a summary of a recent analysis of county medical societies. Starting about 15 years ago, attendance at county medical societies began to tumble. Principal reason was the insistence (by accrediting agencies) that most of the staff attend hospital meetings. A second reason was the growth of local specialty societies. In 1962 and 1963 there was a slight, but not too perceptible, increase in attendance at county medical meetings—probably not enough to be called a trend. Societies of over 1500 members reported a modal attendance of only 9 per cent, and those in the 500-to-1500 member bracket enjoyed a modal attendance of only 15 per cent. Not until the society dropped to the 50-members-or-fewer size, was attendance in excess of 50 per cent.

Yet the county society is uniquely the doctor's "own" organization. Here his earliest capacity for leadership is measured. Here his grievances find a ready ear. Here he has the best chance to get action. Here is the first forum for any scientific or administrative ideas he may have. When it comes to getting community action, the county society is, or should be, the cutting edge of organized medicine. Major civic leaders at national or state level—whether political, labor, management, educational, newspaper, television, ecclesiastical, or business—are harder to reach and influence than the mayor, the superintendent of schools, the shop steward or president of the local union, the town radio station, the newspaper editor, the member of the county or state legislative body, the manager of the town's big industry. Thus the county society can be—and should be—the ideal springboard for interpreting ourselves to the public, for public education in its most constructive sense.

The county medical society is the nursery of leadership in organized medicine. Tomorrow's AMA leaders are even now quietly working away at committee chores in county associations. The doctor's most effective judges are not his co-specialists a thousand miles away but the colleagues he works with day by day.

There is, too, another factor. Most physicians are entering specialties, and the centrifugal force of specialization may impair the sense of brotherhood, the esprit de corps, of our ancient profession. The county society, finding room for all GPs and all specialists, is the one place where they all meet as equals—as professional brethren in the finest sense of the word.

Modern methods of transportation may, one thinks, make the county society obsolete. Let's hope not. Surely the doctor's usefulness to his community should never become obsolete; and the county society is the great arena and testing place of that usefulness.

More Than the Calories

Food in abundance solves the eating problem of any animal except man. A dog or cat will eat the identical food every day of his life if you give it to him. The calories, vitamins, fluid, and salt satisfy his nutritional needs; and, for the

animal, that is all there is to eating. Not so with man. Calories alone will not solve his eating problem. Satisfaction is followed by boredom. In the western world, real physiologic hunger is rare. Eating thus becomes a social and emotional experience rather than a biochemical one. Social criteria are more important in selecting food than the nutritional or biologic factors.

In prescribing diets, doctors naturally think first of the nutritional, biochemical, and physiologic aspects of the problem. However, there is no denying the appetite-satisfying effect of a tasty dish, nor the psychosomatic value of satisfying the appetite. Hospitals long ago learned the importance of presenting meals in an attractive-looking format. Just as romance is more than sexual contact, so eating is more than downing the calories. This is one of the things that distinguishes us from the lower animals in both the sexual and the dietetic sphere.

Even the most appetizing item eventually palls if one has to have it every day. Variety itself seems to furnish the spice needed to make eating more interesting. Doctors in these days of ultra-scientific medicine sometimes forget the value of a little artistry in talking to patients, in writing prescriptions, and in planning diets. One can show artistry without being artful.

Liability of A Consultant*

It is common practice for the names of two doctors to be on a hospital chart. This provides liability for each of them with regard to patient. Where the two doctors are associated in some definite fashion, it is not necessary for the names of both to appear on the chart. Hospital records should indicate that the patient is attended by one physician. The order sheet may show that the doctor who is attending the patient has given his associate or partner the privileges of writing orders in his absence. In this fashion, only one doctor carries the primary legal responsibility.

When a consultant sees a patient, he does not automatically have the right to order for that patient. *He should never write orders* for the patient, unless the attending physician designates on the order sheet that the consulting physician has the authority to order tests, treatment, or medication.

A consultant may have to see a patient two or three times as part of the original consultation. For example, the laboratory or x-ray information may not be available at the time he first sees the patient. In such a case, he should not order any tests, treatment, or medication unless the attending physician has authorized him to do so, *on the order sheet.*

Sometimes a physician sees a patient in consultation and, at the request of the attending physician, continues to follow the patient's course in the hospital. He may write orders for insulin, for diet, or for antibiotics, over a period of days; with or without progress notes on the chart. The physician who does this without written authority is risking additional liability without any privileges.

If the attending physician requires more assistance than can normally be given in consultation, he should:

(a) Transfer the patient to the service of the physician who was the consultant, if the major problem is now in the consultant's field of service; or

(b) He should then notify the patient and his family that there *must* be two doctors formally in attendance (that they both will be charging for services rendered), and he should notify the Admitting Office of the hospital that there are two doctors in full time attendance; and only under these circumstances should both names be on the chart.

Albert Abraham, M.D.

*Abstracted from the September 1963 issue of Morristown Memorial Memogram, of which Dr. Abraham is co-editor.

ORIGINAL ARTICLES

Air pollution is a problem for engineers, meteorologists and others. But physicians should play a leading role here.

The Doctor's Role in Air Pollution Control*

Frank L. Rosen, M.D./Maplewood

Air pollution is deadly. It can kill you quickly, as it did 4,000 in London in one week in December 1952; or 400 Londoners in one week in December 1962. It can kill you slowly with an earlier death from prolonged chronic illness like lung cancer, bronchial asthma, chronic bronchitis, or emphysema.

"The[1] evidence that air pollution contributes to the pathogenesis of chronic respiratory diseases is overwhelming," says Dr. Richard Prindle, formerly Deputy Chief, Division of Air Pollution, U. S. Public Health Service.

Epidemics of air pollution with resultant bronchial asthma, bronchitis, and other respiratory and cardiac aggravations have been described[2,3,4,5,6] in medical literature and received wide coverage by the lay press, television, and radio. In December 1961, in this JOURNAL[7] I reported one such incident in New Jersey which had occurred in November 1953. During a three-day period of temperature inversion (when atmospheric pollutants increased sharply), there was a threefold rise in the number of bronchial asthma patients seen in private practice of allergy.

The individual patient, however, who as a result of polluted air gets bronchitis, running nose, burning of the eyes, asthma, and so on, has received remarkably little attention. In his search for the cause of these symptoms, rarely does the general physician or even the allergist consider air pollution.

What Causes Air Pollution and What to Do About It?

Motor Vehicles

A 40-year-old woman moved to a new home within a block of a heavily travelled highway. Her asthmatic attacks increased in frequency and severity and were relieved only when she moved to a new area.

A 40-year-old man gets asthma attacks chiefly on his way to and from work, while he is in heavy traffic surrounded by noxious fumes. The motor vehicle causes 60 to 80 per cent of the pollution problem in cities. "I thought they had something to put on a car now so that it's harmless," is a remark I hear frequently. The comment refers to the crankcase ventilating device (blowby). The public is being lulled into a false sense of security with this mechanism.

So far as I know, no practical solution has yet been achieved for the tail pipe exhaust. Yet this is responsible for at least 70 per cent of the air pollution from motor vehicles. Automobile companies and the oil industry must embark on a concentrated research program to render car exhausts innocuous. Perhaps there should be a special tax on motor vehicles and gasoline to finance research. A misanthropic wit proposes that the car exhaust be placed not outside but inside the car. This wou'd soon solve not only the problems of air pollution and traffic congestion, but the population explosion as well.

*Read June 20, 1963 at Session on Allergy, American Medical Association.

If nothing develops soon, we may have to go back to the electric automobile. It seems strange that a nation which has sufficient knowledge to shoot missiles to the moon should not be able to control air pollution from automobile exhaust.

Says S. Smith Griswold[8], President of the Air Pollution Control Association: "It is particularly appropriate that our annual meeting will be in Detroit this June, for as we learn more about air pollution the role of our convention city's leading industry is rising in importance. This is an opportunity for air pollution control to bring home to those who control the automobile industry the urgency of taking immediate action to reduce the rapidly rising burden of automotive pollution in the atmosphere.

When the increase in knowledge and accomplishment during the past 12 months is assessed, the facts make clear the need for reducing automotive pollution, and the inexcusableness of further delay . . ."

Industrial Factors

I have several patients who get asthma attacks on days when the wind blows a pollutant from a nearby factory. I have a patient who gets asthma only on days when a neighboring chemical plant makes penicillin. An airport meteorologist told me that many people who work there have nasal and bronchial symptoms when pollutants are blown in from local industrial areas by the winds. A new offender at airports is the jet plane. The takeoff of one commercial jet liner has been estimated[9] to create a quantity of air pollution equivalent to that produced by 6,850 passenger cars.

Sprays and Insecticides

Recently, I saw a 9-year-old boy who would come home with asthma after attending day camp. At first I thought it was due to exertion or exposure to pollens and molds in the fields. I later found that these factors were not the cause, but that he had been exposed to spray (3% Malathion®, #2 Fuel fog machine) in the area. Many day camps spray the grounds daily with insecticides before camp starts. Sufficient time may not be allowed for complete dispersion of the vapor.

The allergic patient suffers to a far greater extent than others, not only from the toxicity but from sensitization reactions to sprays and insecticides.

Leaf Burning

"Last year at least one, and possibly two, deaths were reported in local papers of asthmatic children who died after inhaling the smoke of burning leaves," says a Long Island physician[10].

In the fall, in the suburbs, leaf burning becomes not only an outdoor sport or a pagan rite but a deadly menace for many patients with allergic respiratory disease.

Chapter 6 of our New Jersey Air Pollution Control Code, says:

Prohibition of Air Pollution: No person shall cause, suffer, allow, or permit to be emitted into the outdoor atmosphere substances in quantities which shall result in air pollution. *Open burning of Plant life grown on the premises is not intended to be covered by this code.*

In other words, you can burn your own leaves in your own backyard, even if your neighbor gets an asthma attack from the smoke, as several of my patients do.

Many towns have passed ordinances prohibiting the burning of leaves because of a fire or pollution hazard. Some have determined that it may be stopped if it is a nuisance to a neighbor. Many towns do nothing because—"We cannot afford the cartage and people will not use the leaves for compost."

Pollution from Pollen

Pollen and molds are major causes of air pollution. Ragweed, the most important pollen in the United States (the bread and butter of the allergist's practice) occurs in 5 to 10 per cent of our population.

Meteorologic factors are important in determining the growth and dissemination of the pollen. Since it is wind-borne, its direction is of primary importance. For example, hay fever patients who live in shore areas like Atlantic City do well on days with an ocean breeze. With a land breeze their symptoms are similar to those of their inland brothers in distress. Pollen can blow into a community from hundreds of miles distant. Local laws, even if strictly en-

forced, do not do enough to cut down the amount of pollen in the air. Mamclok[15] has reported from New York City: "Many years ago, after the first frost, when hay fever sufferers stopped sneezing, their symptoms returned. The cause was a windstorm from Louisiana, bringing ragweed pollen from an area where frost had not appeared yet."

Ogden[1] is conducting a research program in New York State whereby ragweed is grown out of season and labeled with radioactive isotopes. The travel pattern of the "hot" pollen is then correlated with metcorologic data.

The higher the ragweed concentration, the more clinical symptoms of hay fever and serious bronchial asthma we encountered.

Proper ragweed control must be considered part of the air pollution problem. It will not only lessen hay fever, but prevent many serious complications like bronchial asthma, which ultimately may develop in one third of hay fever patients.

Ragweed Eradication

A booklet on hay fever revised by the Allergy Foundation of America in August 1962, states: "Even well organized campaigns will fail to be effective if only a single community takes part. The ragweed pollen is so light and floats so far that it is of little use to remove the weeds in a single village or city if they continue to propagate in the surrounding communities and countryside. Weed eradication, to be successful, will ultimately have to be state and nationwide. Many difficulties attend eradication, such as the fact that ragweed grows in grain fields and cannot be easily reached. The seed of ragweed may lie dormant in the soil for 20 years, so that weed eradication must be continued for many successive seasons."

Ruskin[12] reports, however, that "Timely destruction of 3,000 acres of ragweed reduces the pollen pollution by some 75 to 100 tons. This is not to be sneezed at. This reduction has been accomplished in Detroit at an estimated annual cost per hay fever sufferer of less than 30 cents —less than the bus fare for one trip to the allergist's office and back."

The Air Pollution Code of New Jersey, (January 1962) certainly gives authority to eradicate ragweed.

What Can Physicians Do?

We can think about air pollution as a cause of symptoms in many of our patients. I am convinced, after practicing allergy for twenty-five years, that many asthmatics are wrongly labeled psychosomatic, when their trouble is actually coming from polluted air. Studies are now going on in many cities by local, state, or federal authorities to determine the effect of air pollution on bronchial asthma. We, however, must study this effect in our own practices.

The United States Public Health Service, state, city, and county health departments are eager to cooperate with us; but we physicians must be the ones to inform them of the particular problems of our patients. We must contact our local health officers and work with them, especially when we suddenly see large numbers of patients with chronic cough, asthma, and so on, from certain areas of our towns. We must inform our legislators when we see the effects of local air pollution. We must report epidemics of air pollution in the medical literature so that other physicians can be aware of the problem. Interdisciplinary Conferences on Air Pollution must be initiated by the physician. One cannot study air pollution without exchanging information with public health officers, engineers, meteorologists, botanists, and many other allied scientists. The literature often lags a year or more behind events. It is the rare physician who can understand an engineering journal. Few engineers can comprehend a medical journal. Sitting around a table and talking informally in one or two syllable words with our colleagues in allied fields is urgently needed.

As Fremont-Smith[13] says: "Engaging in conversation may be contrasted with making a speech. In the latter, the speaker, although supposedly endeavoring to communicate with his listeners and occasionally succeeding in this attempt, too often is in reality talking to himself and listening with considerable satisfaction to his own voice saying just what he had planned to say! Too often, little or no attempt is made by a speaker to select either vocabulary or conceptual frame of reference with which his audience is familiar. Too often, he tacitly assumes that if communication fails it is the fault of his captive listeners. In speech making, the speaker depends almost wholly upon the power of his transmitting set and pays little or no attention to the quality of the receiving sets of his listeners, many of whom may have highly individual, built-in deaf or blind spots, or distorting lenses which seriously interfere with the accurate reception of the speakers message."

"But", continues Smith[13], "in a conversation the situation is different. In the first place, the participants are more or less on an equal footing. They are,

moreover, engaged in a mutually corrective feedback system which, on the one hand, helps to maintain them on the same wave-length, so necessary for effective communication; and, on the other, indicates promptly by facial expression, gesture, or by verbal interruption whenever communication is in jeopardy or has broken down. In a conversation, as opposed to a speech, interruption is the order of the day and is likely to occur whenever communication is failing, when sharp opposition or sudden illumination and agreement occurs, or whenever new ideas are evoked. Thus, conversation is a process which permits a topic to be discussed in depth, encourages a wider approach to the problem by each of the participants, and provides opportunity for immediate correction of misunderstandings and for lessening of long standing prejudice. Conversation can be enormously stimulating and creative—and not infrequently lays the basis for lasting friendship and cooperation. While these benefits are by no means limited to conversations about science but are in fact universal in scope, they apply with special force to the human beings who are concerned with scientific problems."

Informing the Public

In this age of anxiety we hesitate unduly to alarm our people; yet nothing will be done if the "cold turkey" facts are not presented to them. Television may, indeed, be a wasteland in some respects but it has been a good ally in acquainting the public with the danger of polluted air. In April 1963, ABC-TV showed an illuminating shocker from England called "Smog, The Silent Killer." A month earlier, CBS-TV had telecast an interview with me after my talk on air pollution at the 1963 session of American College of Allergists. In December 1962, NBC-TV presented an effective show about air pollution titled, "Take a Good Deep Breath of Filth." NBC was kind enough to send me a film of this. I showed it to a woman's club and typical comments were: "We were shocked!" "Never knew it was such a health menace. What can we do about it?"

This is what the public can do. We must tell our patients to demand laws for enforcement and money for research from their legislators at all levels of the government.

It is urgent that we have a strong national law on air pollution. We must cross party lines, since the lethal air can chronically poison a Democrat in California as well as a Republican in New York. Remember:

1. The motor vehicle which causes 60 to 80 per cent of the pollution problem in cities constantly crosses state lines, polluting each state impartially.
2. Industry, polluting the air, will move from a state which has rigid enforcement to a state where tolleration exists.

A telegram from Dr. Blasingame, executive vice-president of the AMA, to Surgeon General Luther L. Terry was read at the National Conference on Air Pollution in December 1962. Dr. Blasingame said: "One of our most serious environmental health problems is air pollution. It can and should be controlled. The American Medical Association endorses the concept of local, state, and federal joint enterprise. Enough has been said. Let's clear the air!"

The menace of air pollution is great. Yet, strangely enough, most people consider it no more than a minor annoyance, like an unusual, irritating odor or a larger laundry bill, although it causes losses in the United States estimated[1,4] at $1.5 billion to $11 billion a year. We are more disturbed by local sewage problems, and certainly by the more dramatic but less ubiquitous issue of smoking and cancer.

We have taken great strides in other fields of preventive medicine, but we are only beginning to grapple with the vital problem of air pollution. The air is a giant open sewer; and since we have no choice but to breathe it, it is high time we paid some attention to the garbage we spew into it.

Conclusions

1. Air pollution, a major peril to all of us, is a far greater threat to the allergic patient.

2. During a three-day period of temperature inversion when atmospheric pollutants increased sharply, there was a threefold increase in the number of bronchial asthma patients seen in private practice.

3. The physician must initiate interdisciplinary conferences with other physicians, health officers, botanists, meteorologists, engineers, and others, so that the urgency of this health problem can be related and research stimulated.

4. The public must be alerted to demand appropriate funds for research and control measures against air pollution.

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2130 Millburn Avenue

Insight Spoils "Double Blind" Test

A silly sidelight, but a serious one, is that (FDA) labeling requirements have made some research on patients impossible. The placebo which is used instead of a drug on patients, to make sure that it's the drug and not the patient's attitude that causes changes in his condition, now must be labeled in such a way that he knows when he's getting the medicine and when he's getting the fake. It spoils the experiments.

—Editorial in *Journal of the South Carolina Medical Association,* September 1963.

New Jersey Association of School Physicians

The Steering Committee for the Organization of School Physicians has joined The Medical Society of New Jersey, in conjunction with the Departments of Education and Health of the State of New Jersey in sponsoring a *Workshop on School Health for New Jersey Physicians,* to be held on Wednesday, March 11, 1964, at 3:00 p.m., in the Brunswick Inn, East Brunswick, New Jersey. There will be panel and group discussions of current problems in school health. A Dutch-treat dinner will follow at 6:30 p.m., after which there will be a business meeting of interested school physicians.

The New Jersey Association of School Physicians (in organization) will have a luncheon meeting on Monday, May 18, 1964, at Haddon Hall during the Annual Meeting of The Medical Society of New Jersey.

The new Association is directed by a Steering Committee under the chairmanship of Seymour Kuvin, M.D., Morristown.

The Association is designed to bring together the school physicians in the public, private, and parochial school systems. This will help provide better child care through closer association with the teaching and administrative group.

Founder membership in the New Jersey Association of School Physicians is now offered to all physicians interested in school health. Application should be made to: Seymour Kuvin, M.D., 22 Washington Avenue, Morristown, New Jersey.

Congenital deafness leads to defective speech. Much of it is preventable. More stress should be placed on the training and education of congenitally deaf children.

Congenital Deafness In School Children*

F. Robert Haase, M.D.
Julio T. Noguera, M.D. / **Neptune City**

Congenital deafness may be (1) biologic or (2) pathologic. In this paper, deafness is defined as partial or complete loss of the sense of hearing. *Congenital* deafness may be present at birth; *hereditary* deafness is dependent upon the constitution of the initial cell or cells from which the new life is derived[1].

Kinney[2] has classified congenital deafness on an etiologic and pathologic basis as follows:

1. Hereditary
   a. True Mendelian
      (1) Dominant
      (2) Recessive
   b. Erythroblastosis fetalis
   c. Secondary to other hereditary traits
2. Malformations of the external, middle, or inner ear
3. Occurrences in the mother during pregnancy
   a. Rubella or other virus diseases
   b. Toxic poisoning: quinine, salicylates, alcohol, etc.
4. Intrauterine accidents
5. Birth injuries

All hereditary deafnesses are congenital but all congenital deafnesses are *not* hereditary. Pathologically 70 per cent of congenital deafnesses are of the sacculo-cochlear variety[1]; the others are malformations or affections of the external or middle ear and of the neuronuclear system.

Hereditary Deafness

Hereditary deafness is mendelian in its incidence and constitutes about a third of bilateral congenital deafness, according to several authors. Intermarriage of blood relations continues to be frowned upon in view of the increased occurrence, over normal, of hearing defects and other biologic disorders which may result in deafness.

Erythroblastosis fetalis with kernicterus may cause bilateral perceptive deafness as well as other physical defects, chiefly athetoid spasticity. There is good evidence to show that deafness may occur without spasticity. According to Goodhill[5], 3 per cent of profoundly deaf children were the "probable" result of erythroblastosis. One third of these were spastic. The 3 per cent figure correlates well with that of Bordly and Hardy[4] who found 4 per cent in 296 cases. The lesion is believed to be in the cranial nuclei, resulting from the toxic effect of icteric pigments.

Syphilis, which is again increasing in incidence, is estimated to cause damage to the ear in 6 per cent of hereditary cases. The loss of hearing may be slight during the first few years, exacerbations not occurring until puberty or later, resulting in dysacousia or deafness. Total loss may occur without premonitary signs in days or a few weeks. Pathologically the disease may be manifested in any of the tissues comprising the hearing complex. However, according to Taylor[7], who cited National Research Council studies based on 5,348 congentially deaf children, syphilis plays only a small part as a factor in deafness.

Otosclerosis, as an inherited disease, is an accepted entity discussed so frequently in recent

*Read in Atlantic City, May 15, 1963, Annual Meeting, The Medical Society of New Jersey.

papers that we will not go into it except to point out that (although it is not usually clinically present at birth) it may occasionally be seen in the preschool and school child.

Malformations

Malformations of the external ear, the middle ear, eustachian tube, and inner ear—such as absence or atresia of the external canal, mesenchymatous middle ear, aplasias, and so on—may be present. Aural malformations tend to be familial. Hajek[3] reported seven congenital abnormalities of the middle ear alone, in the course of 123 tympanotomies; Brown-Kelly[13], seven in 100; Hough[14], fifteen in 500. Hough's figures are in keeping with Bordley and Hardy's[4], who found a 4 per cent incidence.

Occurrences In The Mother During Pregnancy

Gregg[1], first drew attention to rubella in the first trimester of pregnancy as a serious cause of congenital defects. Continued reporting in Australian, British, and American literature bear out Gregg's original observations. Goodhill[5] attributed 21 per cent of cases of profound hearing loss to this cause. This was 5.6 times greater than the next most frequent sequelae, which was congenital cardiac defect. Although an epidemic period is included in Goodhill's compilation[5], it is undoubtedly true that rubella is a greater cause of congenital deafness than had previously been realized. Indeed, it represents the largest single category of congenital perceptive deafness.

In a study by Abel and Van Dellen[1], 87 per cent of infants born of mothers having rubella in the first trimester were abnormal; 42 per cent in second trimester; and in the third, probably none. In addition, there is suggestive evidence that congenital defects may occur when rubella is contracted as long as three months prior to pregnancy.

In the area of intoxications, quinine bisulfate and sodium salicylate produce mitochondrial changes in the cells of the stria vascularis and the sensory cells of the organ of corti. More drastic changes in the nature of chromatolysis and loss of ground substance are evident in the spiral ganglion cells after injections of sodium salicylate. In both drugs the alterations were more profound in the basal turns of the cochlea; but over a longer time, the apical turns may also be involved. Fetal guinea pigs exhibited similar but more profound changes to the same drugs when the drugs had been injected into the mother. Salicylate given thirty minutes before delivery has been found in the urine of the newborn; the concentration was greater three hours after delivery and continued to be present in the urine for several days. According to Taylor[7], there must be a definite idiosyncrasy to these drugs for severe degenerative changes to occur although quinine is the more frequent offender.

Deafness in the newborn has also been attributed to chronic alcoholism[1] in the mother. Animal experimentation indicates the selective site of action to be the nuclei of the hair cells of the organ of Corti.

Streptomycin and dihydrostreptomycin[8] are relatively recently-used agents demonstrating ototoxity. Streptomycin has a more severe effect upon the vestibular apparatus and dihydrostreptomycin, upon the cochlea. The effects of the latter may continue to progress in spite of removal of the drug.

Other ototoxic substances are less frequently encountered. These include amiline dyes, phosphorus, lead, carbon monoxide, carbon disulfide, and others.

Intrauterine and Birth Injuries

Intrauterine accidents are usually due to trauma—such as instrumentation, external force, premature separation of the placenta, placenta previa, and so on, resulting in hemorrhage and/or anoxia. Toxemia of pregnancy may also be a factor. Birth injuries include direct trauma—such as instrumentation, too forceful contractions (Pituitrin†) and compression or knotting of the cord in prolonged hard passage with resultant direct injury to the hearing complex or indirect injury by way of hemorrhage and/or anoxia.

†Pituitrin® is the Parke, Davis registered tradename for their brand of aqueous extract of posterior pituitary lobe.

Incidence of Congenital Deafness

In a British report[9], published in 1957, it was estimated that not less than one child in every thousand births had a profound congenital deafness and would *never be able to hear speech*. Another two children per thousand had a sufficient hearing loss to result in lack of ability to hear unaided a teacher's voice in an ordinary classroom. No other reference to congenital hearing loss in the general population was found in the literature. Indeed, it can be seen that this would be a difficult figure to extract since many of these children are removed to special schools or classes for the deaf or defectives long before school age and not included in a general survey. In addition, such congenital conditions as otosclerosis may not appear during the school age.

Dill[10], in a survey of 227 children under fourteen years of age, noted the incidence of nerve and conductive loss to be approximately the same. In the group with nerve loss 72 per cent had a congenital loss and 28 per cent an acquired nerve loss. Fifty per cent of the group with a congenital nerve loss were seen under five years of age.

Ballantyne[11] points out that hearing should be examined in (1) any infant who fails to respond to the normal loud sounds of everyday life; (2) any child whose speech fails to develop in the second year of life; (3) any child with defective speech; and (4) any child whose mother or father suspects that he might be deaf.

Ballantyne[11] quotes Howarth who, under the designation "vulnerable children," combined the above groups with those children who had been affected by one of the known causes of congenital deafness such as otitis media, mumps, or meningitis. In 662 "vulnerable children," the incidence of deafness was 9 per 1000. During the same period, the incidence of deafness in her control group was only 0.65 per 1000; that is, two in over 3000.

Management

The crux of the matter lies in prevention and therapy. Bordley and Hardy[4], in citing 192 diagnosed cases in school and preschool children out of 296 cases of deafness, stated that 88 had been exposed to the causative factor by the time of completion of delivery. This amounts to 40 per cent of the group having a known predisposing factor. From a preventative standpoint, if one considers birth injuries, rubella, and toxemia of pregnancy as preventable and erythroblastosis as controllable, sixty of these 88 cases should have started life with normal hearing. These figures concern only the congenital causes of deafness. When postnatal and natal preventable and treatable conditions such as meningitis, measles, and middle ear disease are added the real goal of decreasing childhood deafness is better visualized.

Two of Bordley and Hardy's patients[4] were born of mothers immunized to, but not contracting, rubeola during their pregnancies. This should lead one to reconsider the sagacity of this procedure during pregnancy. What though of all those children deaf of undiagnosed causes or deaf inspite of prevention and treatment? This is the pressing problem! Doctor[12] of Gallaudet College gave perhaps the best view of the problem when he stated in 1959, that (based on a survey by the Clarke School for the Deaf and the Hearing and Speech Center at Gallaudet College) schools and classes for the deaf needed 500 more trained teachers for the next year and speech and hearing centers needed another 100. At that time enrollment in schools and classes for the deaf had increased over 2000 in just two years.

Conclusions

Congenital deafness has a telling effect in that it invariably involves speech. This obviously results in a late initiation of the learning processes and accumulation of knowledge in an age when education is a paramount necessity.

A large segment of congenital deafness should be preventable.

More emphasis is needed in the area of education and training of the ever expanding numbers of deaf and speech defectives.

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2100 Corlies Avenue

Temporal Bone Microsurgery

Otologists of New Jersey are invited to take a course in temporal bone microsurgery being given in Philadelphia once a month throughout the first five months of 1964. For details, write to Dr. Bernard J. Ronis, at the Department of Otology, 2106 Spruce Street, Philadelphia.

4-Day Graduate Program In Philadelphia

The Philadelphia County Medical Society holds its annual Postgraduate Institute on March 31 and April 1, 2, and 3 at the Bellevue Stratford in Philadelphia. A rich and varied scientific menu has been prepared by a star-studded faculty. For details, write to Dr. Donald Dupler, 301 South 21 Street, Philadelphia, Pennsylvania 19103.

Chest Disease Seminar

You are invited to a clinical conference, seminar, and panel quiz on chest diseases at the Essex House in Newark on Sunday, March 15. This program will run from 9:30 a.m. to 5:00 p.m. and is sponsored by the N. J. Academy of General Practice, which will give 6 hours of AAGP credit for attendance. The New Jersey Tuberculosis and Health Association is a co-sponsor. Topics to be discussed include skin testing, chemotherapy, and chemoprophylaxis. A feature of the day will be a panel of experts who will answer questions hurled at them by the audience. There will also be a clinical conference on nontuberculosis chest diseases. A registration fee of $5 will help defray the costs of publications, food, staffing, and exhibits. The Medical Society of New Jersey is another co-sponsor of this program. For more details, call MArket 3-4810; or write to Dr. Edward A. Schauer at 53 Main Street, Farmingdale, New Jersey 07727.

By meticulously following this check-list, any doctor can acquire an enormous amount of information about an alcoholic patient.

How to Take a History on an Alcoholic

Michael Shenkman, M.D./Westwood

Most doctors do not like to handle alcoholics. One reason is that it is confusing to develop a history that will cover the ground adequately and compactly; give proper weight to ecologic, sociologic, and familial factors; and offer a systematic and not too time-consuming way of getting the needed history. The form offered below has developed out of my experience as medical director of the Alcoholism Treatment Center at Bergen Pines. The physician who conscientiously follows a form like this will:

(1) Face the alcoholic in his office as he does any other patient—with a systematic history-taking approach;

(2) Bring out the existence of factors, if any, which would justify referring the patient to a psychiatrist or to a special clinic;

(3) Facilitate follow-up;

(4) Enable a trained non-physician in the office or social agency to get a compact, usable set of data on the alcoholic; and

(5) If used in the hospital, substantially aid the resident, intern, and attending physician in getting a three-dimensional view of a patient with an alcoholic problem.

The form may be used as a simple check list or guide, the doctor having it on a card or set of sheets which he keeps on his desk or in his bag; or, it may be printed or otherwise reproduced with enough spaces for writing in the answers. It then becomes a history-form.

Identifying Data

Name and address? Occupation? Marital Status? (Note especially if remarried after divorce, or if separated).

How long at present address? (Note if patient moved frequently)

Does patient live (a) alone? (b) with parents? (c) with spouse? (d) with other relatives? or (e) with friends?

How did patient happen to come for this appointment? Was it self-referred? Or referred by spouse, physician, relative, clergyman, police, social worker, labor union, AA, clinic, friend, or whom?

Complaints

Patient's chief complaint—own words.

Does drinking bother him, or bother someone else?

Complaints other than the drinking?

Since when has he been drinking?

Since when has he considered it a bother or a problem?

Any previous effort to get help? How, what help, and what luck with it?

Any experience with AA (Alcoholics Anonymous)?

To whom has he confided his problem?

The Pattern of Drinking

Does he drink: alone? at home? at taverns or bars? at friends' homes?

Does he drink with: spouse? friends? relatives? strangers? co-workers?

How much does he drink?

What kinds of beverages (wine, whiskey, beer, and so forth)?

Does he feel an "urgency" to drink?

If he abstains when he feels the need, what happens?

Does he drink slowly? or does he gulp?

Does he chew or suck lozenges or anything to disguise the odor of alcohol?

Over the years has he become more or less tolerant of alcohol?

Reasons For Drinking

Why do you drink?

What does alcohol mean to you?

How would you define social drinking?

Do you enjoy social drinking?

Can you enjoy the company of friends without drinking?

Do you drink for self-encouragement?

Do you drink to do a better job?

Changes In Pattern

When, where, and how did you have your first drink?

Has there been a change in your way of drinking during the years?

Do you have control of your drinking?

While in company with friends, and while drinking, could you stop while the others continue to drink?

Do you feel you have to have a drink every day? twice a day?

Subjective Symptoms

How often do you get drunk?

Do you have feelings of guilt on account of drinking?

Do you remember next day what happened during or after an episode of drunkenness?

Do you visit friends in their home?

Could you tell how you behave during an episode of drunkenness?

Do you suffer from hangover next morning?

What does "hangover" mean to you?

Do you look for a drink to get rid of it?

Do you have "the shakes" next morning? How do you get rid of them?

Family Aspects

Does your spouse approve of your drinking?

How does he (she) react to your drinking?

Do you, usually, agree to her (his) suggestions for reducing or stopping drinking altogether?

How successful were you?

Are there arguments at home on account of your drinking?

Do such arguments make you angry, furious, guilty, resentful, defensive, aggressive or humble?

Would you say that you are covering up guilt feelings?

How does your spouse react in case of an argument?

Patient's Own Family

Did your father drink? How much? Was he a strict parent? Did he ever beat you? If he is deceased, how old were you when he died?

Did your mother drink? Was she over-indulgent with you? If she is deceased, how old were you when she died?

As you recall them, were parents affectionate or quarrelsome with each other?

Would you say that you had any alcoholics among your brothers, sisters, parents, or grandparents?

How do you get along with your brothers and sisters?

Did you have a happy childhood?

Would you say that you got pretty bad breaks in early life?

Community Aspects

Did your socializing diminish on account of your drinking?

Do you, usually, receive friends in your home?

Are your friends your spouse's friends?

74928

Does your spouse accompany you?
Are you visiting less on account of your drinking?
Are you active in any civic organizations?
Has drinking affected this activity?
Any contacts with the police?
Have you ever been in a traffic accident?
Any trouble with neighbors?

Drinking and The Job

Late to work because of drinking?
Ever miss work on account of drinking?
Does your supervisor know about your drinking?
Did you ever discuss it with him?
Is your job in jeopardy on account of your drinking?
Suppose you are fired, what would you do then?

The Drinker's Family

How many children do you have? What ages?
Do they go to school? Do they work?
Do they know that father (mother) is drinking?
Do the children drink alcoholic beverages? socially at home? at home with parents during meals? occasionally at home? alone? with their friends?

Self-Evaluation

Do you think you are an alcoholic?
Who is an alcoholic?
How would you define alcoholism?
Do your friends and family understand you?
Are you rejected? lonely? jealous?
Are you more jealous now?
Do you have a hobby? Do you have interest in it?
How do you spend free time?

The Drinkers and AA

Did you hear, do you know about AA?
Did you visit AA?
How often did you go?
Did AA help you?
What is your opinion of AA?

Church

Do you go to church?
Did you speak to your Father or Pastor about your drinking?
Did he help you?

The Physician

Does your family physician know about your drinking?
Did he help you?
What did he do for you?

General Health

How do you feel now?
Do you have any complaints about your health?
How is your appetite?
How many meals a day do you eat?
Is there any change in your weight?
Did you ever have bad delirium tremens (DT's)?
How much do you smoke? Cigarettes, pipe, cigars?
Do you take sleeping pills, tranquilizers, bennies, or goof balls?
Any trouble urinating?
How do you sleep?
Is your sex life changed during the last few years?
Does drink make it easier—or more difficult—to get an erection?
Is your spouse less willing to engage in sexual relations if you have liquor on your breath?
Do you have palpitations of the heart?
Would you consider yourself nervous?
Does drinking make you more nervous or less nervous?
What medicines are you taking?
Did any doctor tell you that you ought to take alcohol for medicinal purposes?
Is your handwriting more shaky now than it used to be?

Summary

(The examiner reviews the answers and summarizes here the significant ones.)

199 Honeysuckle Drive

Effective treatment of most cases of skin infection was possible with a neomycin, amphomycin, hydrocortisone compound.

Cutaneous Infections:

A Simplified Technic For Selecting Antibiotic Therapy

H. C. Goldberg, M.D./Plainfield
Seymour L. Hanfling, M.D. East Orange

In treating bacterial infections, early selection of an antibiotic to which the pathogens are sensitive tends to shorten the course of treatment as well as reduce the severity and cost of the illness[1]. In addition, it eliminates the use of ineffective antibiotics which, if used for prolonged periods, may induce bacterial resistance[2] and patient sensitivity[3]. The usual methods for selecting the proper antibiotic require special equipment or are time consuming. Hence, in office practice (where most infections are treated) antibiotic therapy is usually chosen empirically which, according to one report[5], is in error at least 25 per cent of the time. There is, obviously, a need for a simple, inexpensive technic for determining bacterial sensitivity that involves a minimum of equipment and time, and that lends itself to routine use in the office. This would simplify and improve the treatment of infections. Such a technic* has been developed and was used on some patients with dermatologic infections who were treated during the evaluation of a topical antibacterial-steroid preparation† containing a new antibiotic, amphomycin.

Material and Methods

The topical preparation under evaluation contained calcium amphomycin (0.5 per cent), neomycin sulfate (0.5 per cent), and hydrocortisone acetate (1.0 per cent) in a water-miscible, vanishing cream vehicle.† The antibacterial properties of neomycin and the anti-inflammatory properties of hydrocortisone are well established. Amphomycin is a polypeptide antibiotic with antibacterial properties similar to that of penicillin and bacitracin[6,7,8,9]; it is particularly effective against certain resistant strains of staphylococci[7]. Isolated from *Streptomyces canus*[7] in 1952, amphomycin has been used, either alone or in combination with neomycin, rather extensively abroad in the treatment of skin infections. It has been but little used in this country. European reports[10] indicate that a greater number of pathogens isolated from dermatologic infections are sensitive to amphomycin-neomycin[11] than to either penicillin, streptomycin, or to bacitracin-neomycin[12]. The antibacterial superiority of this combination of antibiotics, together with the fact that amphomycin can be formulated in a water-miscible vehicle and has an extremely low potential for inducing irritant and/or sensitivity reactions, has broadened the interest in this antibiotic during the last 18 months.

During the current evaluation, 261 patients received the amphomycin-neomycin-hydrocortisone preparation for the treatment of primary or secondary skin infections (see Table II). The primary infections were selected to see whether the activity of the antibiotics was altered by the presence of hydrocortisone. Topically, hydrocortisone may in fact indirectly curtail bacterial multiplication by reducing inflammation and its products, both of which constitute a good medium for bacterial growth[13]. There is, in addition, evidence[14] that topically applied steroids in combination with antibiotics may be more effective than when used alone.

*We used the Bacterial Culture and Antibiotic Sensitivity Kit, a product of Fungus Diagnostic Services, Plainfield, N. J.

†Amphocortrin® Cream, kindly supplied by Warner-Chilcott Laboratories, Morris Plains, N. J.

All patients were instructed to apply the white vanishing cream, lightly and with a minimum of friction, to the infected areas three or four times daily, and to follow hygienic measures appropriate to the condition involved. All practical measures were taken to insure contact between the medication and the base of the lesions. Crusts, scales, and other debris were removed from the surface of all lesions and, when indicated, measures were taken to insure drainage. In each case an underlying cause (such as diabetes or anemia) was sought and eliminated whenever possible. In an effort to prevent a recurrence, other foci of reinfection were sought and treated when found. Sources of irritation and maceration were eliminated, and in certain conditions (such as acne or eczema), dietary prohibitions were prescribed. So that the response to the test preparation could be determined as accurately as possible, no additional medication was prescribed. Patients with acute disorders were told to continue treatment with the test medication for 7 days. Those with chronic disorders were instructed to continue treatment for 14 days. Patients were seen frequently during each test period. On completion of treatment, the clinical response was judged according to the following criteria:

Satisfactory Response:	Elimination of the infection and complete or nearly complete healing of the associated inflammatory skin reaction;
Unsatisfactory Response:	All other responses, including a worsening of the infection or associated inflammatory skin reaction.

Prior to the initiation of treatment in a portion of the patients (50 in all) *in vitro* sensitivity tests were carried out on exudates or the pathogen material obtained from the infected site. This involved the use of a Bacterial Culture and Antibiotic Sensitivity Kit,* which consisted of a sterile, clear broth in a dropper bottle, a suitably prepared, stable medium in a Petri dish, and a set of antibiotic sensitivity discs. In addition to being convenient for office or hospital use, we have found that the *in vitro* sensitivity results obtainable with this method correlate well with clinical responses[15] and with sensitivity information obtained with the more complicated and less convenient multiple tube dilution method[16]. An outline of the method follows:



A minute amount of pus, serum or exudate, was obtained from the infected area with the aid of a sterile dropper (provided in the kit). The material was dropped into the bottle containing the broth, and the bottle was placed under a desk lamp to "incubate." A few hours later when the broth had become turbid (an indication of bacterial growth), a few drops of the broth were spread smoothly over the surface of the Petri dish containing the stable medium. The antibiotic-containing paper discs were then placed on the inoculated surface of the Petri dish and incubated for an additional 8 hours. At the end of this period the Petri dishes were checked to determine the sensitivity of the pathogen. A clear zone around a disc was accepted as an indication that the pathogen was sensitive to the antibiotic present in the disc; the absence of such a zone was considered as an indication that the antibiotic in that particular disc was ineffective against the pathogen (Figure 1).

Results

Pre-Treatment Sensitivity Findings — Results with the simplified sensitivity-testing technic used in conjunction with the Antibiotic Sensitivity Kit* on the specimens taken from the randomly selected group of 50 patients are presented in Table I. In addition to amphomycin and neomycin, the antibiotics present in the test preparation, bacitracin, polymyxin, and penicillin were also used in the sensitivity tests. More than one organism was isolated and identified in the specimens obtained from 7 of the 50 patients. The sensitivity of only the predominant organism was included in the tabulations. Gram-positive organisms were identified as the pathogen much more frequently than were gram-negative organisms. This is in keeping with the usual incidence of pathogens found in cutaneous infections. The present bacteriologic findings, despite the small number of strains studied, are consonant with those of others regarding amphomycin and indicate that the an-

tibacterial spectrum of this antibiotic is limited, with few exceptions, to gram-positive organisms.

The high ratio of gram-positive organisms sensitive to both neomycin and bacitracin shown in Table I was unexpected and does not conform

TABLE I

SENSITIVITY OF ORGANISMS TO ANTIBIOTICS INCLUDED IN TESTS

Orgonism	No. of Times Isolated	Per Cent Sensitive To:				
		Ampho-mycin	Neo-mycin	Bocitro-cin	Poly-myxin	Peni-cillin
Staph. albus	18	83	100	88	77	82
Staph aureus	19	89	95	85	15	25
AVERAGES:		86	98	87	46	54
Coliform	9	67	89	44	44	33
Pseudomonas aeruginosa	2	100	100	100	00	50
Proteus vulgaris	2	00	50	00	50	50
AVERAGES:		56	80	48	31	44
OVER-ALL AVERAGES*		71	89	68	38	49

* Grom-positive and Gram-negotive organisms combined.

with our previous findings with these antibiotics. This is particularly true for bacitracin. It does not agree with the findings of others which have shown that this antibiotic is effective against fewer resistant strains of staphylococci than is amphomycin. While a number of factors could account for this divergence, one of the most plausible is that the strains of staphylococci tested in this series were mostly of the sensitive variety.

Clinical—The response to treatment is given in Table II. Note that 107 (88 per cent) of the patients with acute, primary skin infections responded satisfactorily to the amphomycin-neomycin-hydrocortisone cream. Results were judged after seven days of therapy. As is usually the case, response to treatment was less impressive in the patients with chronic recurrent infections that were secondary to a dermatitic condition. In this group 87 (63 per cent) of the patients were judged to have shown a satisfactory response following 14 days of treatment. As indicated in Table II, the generally poor response of patients with pustular acne accounted for well over half of the unsatisfactory results among the patients with chronic disorders.

TABLE II

CLINICAL RESPONSE TO TREATMENT* WITH AMPHOMYCIN-NEOMYCIN-HYDROCORTISONE (AMPHOCORTRIN ®) CREAM

Diognosis	Total Coses	Patient Response	
		Sotis-factory	Unsatis-factory
ACUTE DISORDERS			
Cellulitis	9	8	1
Folliculitis	21	18	3
Furunculosis	10	7	3
Impetigo Contagiosa	28	23	5
Paronychia	5	5	0
Post-operative infection	34	34	0
Post-traumatic infection	9	9	0
Miscellaneous	6	3	3
TOTALS	122	107 (87.7%)	15 (12.3%)
CHRONIC DISORDERS**			
Contact Dermatitis	10	8	2
Dermatitis Factitia	3	2	1
Eczematoid Dermatitis	2	2	0
Seborrheic Dermatitis	5	3	2
Stasis Dermatitis	4	2	2
Dermatophytosis	7	5	2
Dyshidrosis	21	16	5
Pustular Acne	61	29	32
Atopic Eczema	5	4	1
Neurodermatitis (circumscribed)	10	9	1
Miscellaneous	11	7	4
TOTALS	139	87 (62.6%)	52 (37.4%)

* Judged in ocute disorders after 7 days, ond in chronic disorders after 14 doys.

** Infection recurrent and secondary to dermatologic diagnois.

These results were not unexpected, however. Being an unusually deep seated infection, pustular acne rarely responds favorably to short-term, topical therapy. These patients were included in the evaluation to determine whether the test preparation (because it contained a

new antibiotic) might be unlike other topical preparations and prove effective in the treatment of this disorder. By eliminating these patients from the series, we could report satisfactory results in 74 per cent of the patients with chronic disorders. This is more indicative of the improvement normally expected to occur with an effective topical preparation. The best results with the test preparation occurred in such acute disorders as paronychia and post-operative and post-traumatic infections, and in such chronic infections as those secondary to contact dermatitis and circumscribed neurodermatitis. In these (and in most other diagnostic groups) symptomatic relief was generally rapid. Itching, burning, and pain were usually relieved (completely in many instances) within 24 hours following the initiation of the topical agent being evaluated. Erythema, edema, vesiculation, and other common inflammatory signs began to dissipate by the end of the first 48 hours of treatment. Only one patient who initially showed a satisfactory response to treatment experienced a recurrence of the infection ten days after therapy was discontinued.

Untoward Effects

No systemic reactions were noted during the course of the evaluation, but this is not unusual, since such reactions are not generally expected with topical agents. There was no evidence of sensitization reactions in any of the patients, including those who continued to use the amphomycin-neomycin-hydrocortisone cream beyond the formal evaluation period, as well as the small number of patients who received a second course of treatment with the medication. Dermal irritation was observed in two patients with hypostatic leg infections; in both, irritation was moderate and disappeared promptly when the medication was discontinued. We did not try to determine which of the components of the preparation was responsible for the reaction.

Correlation with Response

In Table III, sensitivity findings are correlated with clinical response. Since the chronicity of the infections determine the duration of treatment with the test preparation (as well as the time at which responses to treatment were judged) the data in this table are grouped as to whether the pathogen was isolated from either an acute or chronic infection. In 58 per cent, we found a positive correlation: the sensitivity findings to amphomycin or neomycin (or both) were such that they agreed with the clinical response, occurred in 29 (that is 58 per cent) of the patients. By most standards, this incidence of correlation is low. It should be noted, however, that the lack of positive correlation (in other words, the presence of a negative correlation) was accounted for, primarily, by a single group of patients: those with pustular acne. Sensitivity findings and clinical responses agreed in only 4 of the 19 patients with this disorder. The poor clinical responses evident in patients with this disorder were not unexpected, since the foci of this infection is generally deep-seated and, apparently, well below the level of the dermis to which topically applied medications are able to penetrate. If the patients with pustular acne are eliminated from the tabulations in Table III, sensitivity findings correlate with the clinical response to the amphomycin-neomycin-hydrocortisone cream in 25 (81 per cent) of the remaining 31 patients.

TABLE III
PRETREATMENT SENSITIVITY TO AMPHOMYCIN AND NEOMYCIN AND CORRELATION WITH CLINICAL RESPONSE

Organism	No. Times Isolated	Amphomycin		Neomycin		Clinical Results		Correlation	
		S	R	S	R	Sat.	Unsat.	Positive[1]	Negative[2]
Coliform	4	2	2	4	0	3	1	3	1
Staph. aureus	7	5	2	6	1	4	3	5	2
Staph. albus	6	5	1	6	0	5	1	5	1
Pseudomonas aeruginosa	1	1	0	1	0	1	0	1	0
Proteus vulgaris	2	0	2	1	1	2	0	1	1
SUBTOTAL[3]	20	13	7	18	2	15	5	15(75%)	5(25%)
Staph. aureus	12	12	0	12	0	8	4	8	4
Staph. albus	12	10	2	12	0	2	10	2	10
Coliform	5	4	1	5	0	3	2	3	2
Pseudomonas aeruginosa	1	1	0	1	0	1	0	1	0
SUBTOTAL[4]	30	27	3	30	0	14	16	14(47%)	16(53%)
COMBINED TOTAL	50	40	10	48	2	29	21	29(58%)	21(42%)
% SENSITIVITY		80	20	96	4	58	42		

[1] Positive correlation indicates that clinical response (satisfactory or unsatisfactory) could have been predicted from sensitivity findings.

[2] Negative correlation indicates that clinical response differed from that which could have been predicted from sensitivity finding.

[3] Isolated from patients with acute disorders.

[4] Isolated from patients with chronic disorders.

Comment

The clinical results reported herein conform, in most respects, with those reported by other American investigators. For example, the overall response of patients with acute infections in our series approximates that cited by Cahn and Levy[17] for patients with primary pyodermas. Although they treated few patients with acne, Cahn and Levy found, as we did, that the test preparation was less effective in patients with infections that were secondary to dermatologic disorders[17]. Our findings in patients with nummular or dyshidrotic eczema do not, however, bear out the experience of Cahn and Levy[17], who reported "consistently poor results (9 of 11 patients)" in a similar indication (exudative neurodermatitis). Robinson and Roberts[18] had results similar to ours in patients with pustular acne. Duration of treatment with the test preparation was considerably longer in their series. On the basis of our experience with the antibiotic-steroid preparation in such areas as the axillae and scalp, we agree with previous investigators[17] that the base of this preparation is essentially non-occlusive. Because of the ease of application and lack of "greasiness" of the hydrophilic, vanishing cream-type base, patient acceptance of the amphomycin-neomycin-hydrocortisone cream was excellent.

Summary and Conclusions

1. In 261 patients with skin infections (approximately half of which were secondary to various dermatic lesions or underlying skin disease), the sole treatment used was the topical application of amphomycin 0.5 per cent neomycin 0.5 per cent and hydrocortisone 1 per cent in an oil-in-water emulsion†.

2. Satisfactory results were obtained by 165 (83 per cent) of 200 patients. In the remaining 61 patients, all with pustular acne, satisfactory responses occurred in only 29 (47 per cent). No sensitivity reactions were observed. However, two patients, both of whom had hypostatic leg infections, complained of dermal irritation.

3. *In vitro* sensitivity testing of the predominant infecting organism isolated from 50 of the 261 patients, indicated greater sensitivity to amphomycin than to bacitracin, penicillin or polymyxin.

4. Clinical response correlated with the sensitivity findings in 81 per cent of the patients tested, excluding those with pustular acne.

5. Amphomycin - neomycin - hydrocortisone (Amphocortrin®) in an oil-in-water emulsion base† is an effective topical antimicrobial medication for the treatment of a wide variety of primary and secondary skin infections.

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7 Watchung Avenue (Dr. Goldberg)

Pain seldom belongs to a single specialist. It is so varied in its source and manifestations that the general practitioner should be the first to try to cope with it.

Pain II*: Whose Business Is It?

Fred A. Mettler, M.D./New York

It would seem that pain must initially be the concern of the general practitioner. The obvious requirement placed upon the first physician confronted by a patient complaining of pain ought to be the clarification of the subjective sensation which the patient says he is experiencing. This is a prerequisite to the formation of an opinion as to what the nature of the underlying anatomophysiologic mechanism may be[1]. In most cases, what the patient complains of is chronic, dull, aching pain.

There are, however, differences within this great category which require explication. For example, the paresthetic features which separate a post-herpetic neuralgia from neuralgias caused by nerve compression, let us say, can be detected only by a properly structured examination which presupposes an adequate history. In the course of his preliminary collection of data the physician may gradually get the feeling that the complaint of the patient does not directly accord with any simple anatomophysiologic explanation. He may be surprised, on the one hand, by inconsistencies in the anatomic implications of the complaint. More frequently, he senses a certain elusive, protean factor in the complaint and a tenacity on the part of the patient to cling to pain as though it were, as Kolb has said, "an old friend." If such inconsistencies or extraneous factors are detected, the general practitioner must swiftly decide whether to temporize with drugs or ask for a consultation. But whom should he consult? If he is dealing with a peculiar structural problem, should the patient be asked to see an orthopedist, neurologist, dental surgeon, or any of the other organic specialists—or should the patient be referred, perhaps, to a psychiatrist? There can be no question of temporizing. The presenting question is really whether to direct one's attention to structural substrate or to the dynamic mechanisms of personality adjustment. Few patients have the funds or time to traipse about the countryside from one x-ray room to another. A laborious elimination of one organic possibility after another may perhaps be avoided by some attention to elementary psychiatric principles.

Psychiatric Referral

There are some obvious difficulties with psychiatric referrals. Apart from the stigmatization of the patient and his resistance to referral to a "'head-shrinker", superior psychiatric service is difficult to get and often prohibitively expensive in time and money. Referrals to psychiatric consultants often turn out to be undirectional. Most psychiatrists seem to take it for granted that patients are sent to them for diagnosis *and* treatment; but the kind of psychiatric attention the average pain case requires is well within the scope of the ability of even the busiest general practitioner *once he has been assured of the nature and extent of the personality problem.* It is in connection with this latter point that differences of opinion arise. Many psychiatrists insist that they require an economically impractical attendance before they can accumulate and evaluate the necessary per-

* Based on a staff conference address by Dr. Mettler on March 28, 1963 before the Anesthesiology Department of Columbia University's College of Physicians and Surgeons.

sonality data. Things do not always have to be difficult. It requires no elaborate special training in psychiatry to recognize that the subjective complaint (and experience) of pain is less closely related to the amount of bodily damage than it is to the significance the patient attaches to this damage. Every physician who is in a type of practice in which he alone is responsible for the care of his patient realizes that people vary enormously with regard to what they call pain, and in their susceptibility to what everyone would agree must be painful. It does not take him long to find out that such variation extends to surprising and disappointing differences in the efficacy of various drugs and therapeutic procedures, including nerve blocks and expensive, destructive surgery. He also is willing to acknowledge the essential truth in the psychiatrists' admonitions that pain has important psychic concomitants. He is, in short, in a good position to make a beginning in the treatment of pain by psychodynamic technics; and he should do so, not only because patients with pain will rarely go to a psychiatrist and seldom have the necessary funds or time but more especially because pain patients are generally not regarded by psychiatrists as "good" patients.

Of course, a physician is not entitled to "good" patients; but, since the direct appeal of a patient in pain requires the physician who is primarily a medical theorist or technician to drop doctrinaire approaches and assume the responsibility of the traditional medical ethos, this is an uncomfortable situation for the specialist who does not wish to meet the patient on the patient's own terms but insists on having the patient meet his medical attendant upon a desirable professional level. However, in the last analysis, every physician must face up to the fact that he is just a doctor, with a doctor's ordinary responsibility to act as effectively as he can, regardless of doctrinal allegiances. He must realize that theoretically unclarified pragmatic approaches, which get results, are much to be preferred to elegant and scholarly speculations which end by the patient going elsewhere, or in a referral of the patient to someone else.

While it is customary to consider pain a "sense", Weber[2] long ago pointed out that the "sense" of pain does not convey objective information in the way in which the other, more properly termed, senses do. It is an *affect*[3]. The key to the complexity of pain is its wholly subjective nature, and it takes time and patience (a lot of both) and intelligence (a little, anyway) to dig this out.

The Dynamics of Pain

We cannot employ any objective measure of pain. We must accept the patient's own estimate. "For marking the threshold of pain, the verbal report of an instructed subject is the most reliable evidence."[4] While it is true that pain generally is developed when stimulation is of such a nature as to destroy tissue, the destruction of tissue cannot be used as an objective corollary since people who exhibit no obvious tissue destruction may complain of pain and those who do have destruction may not complain. Leriche[5] points out that by the time the patient is aware of pain the first act of the drama of disease is often already over, and it is too late to stop the process. We all know that psychotics may not *suffer* from pain when they "should", and that lobotomy produces a disregard of pain even though in neither of these conditions is there any regular, marked increase in the threshold of pain and, therefore, no break in the mechanism for the conduction of impulses responsible for potentially painful experience.

Although the complaint of pain usually has primitive (if not technically "protopathic") affective aspects (pain is experienced by infants as well as sophisticates), and usually does accompany tissue destruction, it is accompanied by a more important, and consistent, third phenomenon—the dissociation of concepts from percepts. Pain encourages the individual to indulge in a flight from reality, to dissociate the "self" from the "body". Such a dissociation may have a psychologic, rather than a somatic traumatic origin, and the end result of the process due to a psychologic cause may be indistinguish-

able from that due to a somatic cause. When such withdrawal is initiated by definite somatic trauma, but is subsequently discovered by the individual to have independent psychologic significance, the patient's report of his pain may be inexplicable unless one keeps in mind the fact that the experience of pain involves the subjective factor of its meaning to the patient. This meaning may be either threatening or exaltative. The patient may view the pain as a threat to the continued development, or even existence, of his self. Slight discomfort may produce panic (which is an unreasoning dissociation of the perceptual and conceptual functions) as a result of its warning of vulnerability ("pain is death's shadow and its voice warning us[3]").

On the other hand pain may open the door to a vista of the relief available through dissociation of the self from the demands of a domineering materialistic existence ("suffering, fulfilling the purpose of human life".)[3] In the first case pain confuses and blocks constructive activity. In the second the patient's daily duties and social contacts suffer because he has learned that (so long as he remains out of contact with his environment) his pain is not only reduced but he becomes indifferent to the "slings and arrows" of the outrageous fortune which besets us all. He has, in short, achieved an ineffable mystical state which is well known to the adepts of many religious and philosophic systems. This is not a psychotic condition, but it may be necessary to differentiate it from psychotic states. It is precisely because pain has these three principal aspects (it is an affect, rather than a sense; it may or may not exist with tissue destruction; and it always involves a dissociation of concept from percept) and two subjective meanings (it may signify a threat to a happy life, or relief from an unhappy one) that it has been such a troublesome subject for anatomists, physiologists, and psychologists to discuss within their own frame of reference. It did not encourage the anatomist to learn from the early neurologists that persons who show no structural anomalies whatever may be indifferent to pain[6] from the day of birth, nor for the psychologist to discover that the absence of painful experience in such individuals does not greatly disorganize their psychologic processes.

There are, however, in the fields of the neuroanatomy and neurophysiology of pain certain areas of opinion which have been the site of more or less focal struggling. It is necessary for the general practitioner to be acquainted with the principal issues in these areas if he is to be considered reasonably *au courant*. These will be discussed in the following communication[7].

Summary

Pain is an experience which can be erected on an extremely variable terrain. It can shift its ground and can call for a variety of auxiliary reactions. The physician cannot cope with pain unless he realizes all this. The ground on which pain can pitch its tent may be in any of several provinces of the specialties. Often, therefore, it is not easily dealt with by a particular specialist. The general practitioner seldom has time to hold fast to a pain problem (while pain goes through its usual protean changes). It is therefore not often successfully treated in general practice. In spite of these difficulties it is preferable for the general practitioner to try to analyze fully any pain problems which he encounters. If the patient is referred to the wrong type of specialist, not only may a long, expensive, fruitless round be initiated, but the global aspects of the problem may become obscured.

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630 West 168 Street

The poignant tragedy of the injured children throws into bold relief the responsibility of the physician for swift, often life-saving, action.

Pediatric Evaluation of the Injured Child*

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The evaluation and care of the critically injured child requires the close co-operative efforts of the surgeon and pediatrician.

Nature of the Injuries

A 1961 survey[1] of injured children at the Boston Children's Hospital revealed 406 patients with injuries as listed in Table I. Skull fractures and head injuries comprise nearly one-third of the cases; general trauma and other fractures followed, with one-fifth of the cases being in each category. Burns were present in only 9 per cent. A 1962 survey of 414 injured children at the Jersey City Medical Center, N. J. disclosed similar findings.

TABLE I

Types of injuries and accidents in 406 cases reported in the 1961 Annual Report of the Childrens Hospital Medical Center in Boston.

per cent	
30.2	Skull fractures and head injuries
20.4	general trauma
19.2	Other fractures
11.8	Poisonings
11.8	Poisonings
9.2	Burns
9.2	Inhaled foreign bodies
100	per cent

General Immediate Care

The initial care of the critically injured child is essentially that of first aid in an effort to maintain life. The upper airway should immediately be examined to remove obstructions, such as those due to broken dentition or food in the mouth at the time of accident. It does little good to resort to positive pressure oxygen or mouth-to-mouth resuscitation if obstructing material has not been removed. All physicians should be familiar with mouth-to-mouth resuscitation in the child who has had respiratory arrest.

Simultaneously, or as soon as possible, the presence or absence of heartbeat should be determined. If cardiac arrest has occurred, external cardiac massage should be promptly started[2] to [5]. One hand or a firm mattress should be beneath the thorax, and three fingers[3] or the thumbs of both hands should compress the middle sternum with sharp, vertical thrusts[2], approximately 3 or 4 centimeters at 80 times per minute[2,5]. The blood pressure should be determined and followed while using this method. The complications[4] ensuing after improper technic include ruptured livers, fractured ribs, hemothorax, hemoperitoneum, and fatty emboli from the bone marrow. Stimulants will usually be necessary.

All hemorrhage must be stopped. Blood should be withdrawn for cross matching for transfusions, and a cut-down should be performed for intravenous fluid therapy. If the patient is in an extreme state of shock (so that the cut-

*Presented at Atlantic City before joint session Pediatrics and Surgery, The Medical Society of New Jersey, May 13, 1963

down vein is too constricted for canullation) it is senseless to go on attempting cut-downs at other sites. At that juncture, it is still possible to put the patient in Trendelenberg position, insert a needle into the external jugular vein, which is almost always readily canullated, and allow colloid or normal saline to run in at a rapid rate. An assistant can hold the needle in position. After one hour of such therapy, the patient's blood pressure has usually been elevated to a point where canullation at the cut-down site can be more readily performed.

As recently cited for adult patients[6], there are many specific etiologies for so-called "irreversible shock." However, the cause of shock in the critically injured child will most often be that of hemorrhage or burn and will require blood and/or other fluid therapy.

The patient's clothes should be removed not only to permit rapid physical examination, but also to get rid of persistently wet and hot materials in cases of scald burns. X-ray examination should be done as indicated by his injuries.

An unconscious patient needs a gastric aspiration. It is to little avail to have the child survive his injury but expire because of vomiting and aspiration pneumonitis[7].

To give tetanus antitoxin is to risk immediate anaphylaxis or subsequent serum sickness. It is well worth the seconds required to elicit a history of previous immunizations against tetanus. There is excellent antibody response to boosters of tetanus toxoid given as long as 14 to 18 years after initial immunizations[8].

Most injured pediatric patients require antibiotic coverage because they have had a break in their ectodermal or endodermal protective barrier.

Head Injury

The patient with the severe head injury is usually unconscious and, occasionally, convulsing. Intravenous fluids are necessary, but an effort should be made to keep him on the "dry side" by using 75 per cent of the normal maintenance fluid requirements[9]. If the child has a seizure, it is best to avoid long-acting anti-convulsant therapy, since this may later contribute to the respiratory depression developing as part of central nervous system damage.

Urethral catheterization may lead to complications from urinary tract infections; but it is of aid in following urinary output and in preventing the restlessness that occurs in the unconscious patient with a distended urinary bladder.

If the patient shows signs of papilledema and rising intracranial pressure[10], intravenous urea† may be extremely helpful. This will reduce cerebral edema with little, if any, rebound phenomenon. Urea causes a diuresis, and therefore urine output must be carefully observed and equilibrated by intravenous fluid therapy. Urea is contra-indicated in children with renal disease or disfunction. In rabbits, massive doses of urea, while having little effect on serum sodium and chloride levels, caused severe and lethal acidosis with serum pH levels of 6.7 to 7.0 being noted[11].

Occasionally, a patient requires tracheotomy and respirator therapy because of marked respiratory depression and hypoventilation. Respiratory depressant agents should be avoided at all costs in the treatment of head injuries.

If the patient pursues a downhill course, hypothermia may be considered. Although used for other types of shock[12], hypothermia produces its best results in cases where central nervous system anoxia plays a major role[13]. Hypothermia may help lower intracranial pressure[7]. In a large series of cases, hypothermia[12] was found to be relatively inefficient in the face of marked central nervous system hemorrhage. Hypothermia is more effective when combined with the "lytic-cocktail" (1:1:2 chlorpromazine: promethazine: meperidine with chlorpromazine 1 milligram per milliliter made up as a solution giving 0.3 milliliters per milligram)[12]. The "lytic cocktail" has been used in conjunction with hypothermia at the Jersey City Medical Center. Other workers[13] have preferred to use chlorpromazine alone (0.5 to 1 milligrams per kilogram). Pressor agents are contra-indicated when using these technics.

† Half Gram per kilo of body weight in 4-15-30 per cent solutions; every 8 to 12 hours. Give at 60 to 80 drops a minute.[10]

An incompletely evaluated but possible aid in therapy is hydrocortisone. Shenkin[14] made use of the fact that there is normally a rise in blood pressure and decrease in pulse when the patient with elevated intracranial pressure has a convulsion. He observed that certain patients with head injuries and convulsions appeared to be in shock, with a *decrease* in blood pressure and a *rise* in pulse. He attributed this to transient adrenocortical insufficiency and his patients responded to intravenous steroid therapy.

The Child with General Trauma

Battered children may have ruptured spleens, livers, adrenals, and other organs; and might have hemothorax and pneumothorax without evidence of rib fractures. In any event, they require blood transfusions in sufficient amounts to restore a near normal blood pressure. Ten cubic centimeters per pound is the rule of thumb for transfusing pediatric patients; but a hemorrhaging patient may well require a greater amount. If the blood is over 5 days of age, it is best not to use it. Small patients may experience severe electrolyte imbalances if large amounts of aged blood are used.

The pediatrician should insist that any child with hematuria subsequent to minimal renal trauma have an intravenous pyelogram before discharge. Generally, the easily traumatized kidney is the one with congenital malformations.

Other Fractures

Children with certain fractures may present the problem of renal shutdown. These patients may have anuria because of crush injuries or because of incompatible blood transfusions. The goal is to keep the child alive through the course of what is usually a reversible renal lesion. Their intravenous fluids have to be governed by their extracellular fluid electrolyte determinations; but in general, range from 20cc./kg./day for the infant to 12cc./kg./day for the older child[15]. These amounts compensate for daily water requirements and small amounts of urine output. If the child is on oral as well as intravenous fluids, the total fluid limits are the same. The diet should be high in carbohydrate and fat but devoid of protein. Daily weight loss is to be expected.

Initially, the problem of hyperkalemia is the most pressing one[15]. Kayexalate® resin (1 gm./kg.) can reduce serum potassium by nearly 1½ mEq per liter in 6 hours. Glucose can help carry the potassium out of the serum and into the cells. Intravenous calcium gluconate is effective against the myocardial toxicity of potassium. However, as the potassium rises, it usually becames necessary to resort to peritoneal dialysis (60-105 cc./kg. with added heparin and tetracycline introduced in 20 minutes for 1 to 2 hours, gravity drain). This will remove potassium, but is ineffective in lowering blood urea nitrogen. If available, hemodialysis is the most effective means of lowering both these toxic electrolytes. *Fresh* whole blood exchange transfusion does not efficiently lower potassium or BUN levels, but is extremely beneficial in treating the hypervolemic congestive heart failure seen in some of these patients.

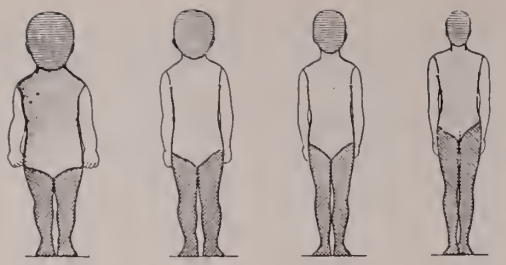
The patient with congestive heart failure represents one who has been overhydrated. Such a child will show a poor response to digitalization. Similarly, the patient may have hypertension on a hypervolemic basis, and reserpine therapy is only moderately effective.

Deaths in acutely anuric children[15] are due to infection and electrolyte imbalance. In the latter group are fatalities occurring during the polyuric phase at which time the patient is recovering from his renal lesion. In the polyuric stage there is a marked loss of sodium and potassium with less in the way of water loss.

The Child with Burns

If a child is burned, the first evaluation must always be concerned with his airway. If there are severe facial burns consider a tracheotomy under bronchoscopy before marked swelling of the cervical tissues has occurred[16].

Intravenous fluid therapy is dependent upon the estimation of the depth of the burn and the percentage of body surface burned. The usual tendency is to overestimate the damage. As shown in the figure, the rule of nines can still be applied to the varying age groups if there is alteration of allowances for head and lower extremities.



	NEWBORN	3 YEARS	6 YEARS	12 + YEARS
HEAD	18 %	15 %	12 %	6 %
TRUNK	40 %	40 %	40 %	38 %
ARMS	16 %	16 %	16 %	18 %
LEGS	26 %	29 %	32 %	38 %

Relative proportions of the principal areas of body surface at various ages.[16]

In the newborn, the head comprises 18 per cent of the body surface and decreases by approximately 1 per cent per year of age to a 6 per cent value. The legs in the newborn comprise 26 per cent, and gain approximately 1 per cent per year of age[16] to a total of 38 per cent. Fluid therapy is calculated to a maximum of a 50 per cent second or third degree burn. The following fluids are usually given[16] to [19]:

Colloid: 1cc./kg./percent second or third degree burn

Normal Saline: 1cc./kg./percent second or third degree burn

Dextrose Solution (5 per cent): maintenance requirements for age.

One-third to one-half of the colloid and saline is given in the first 6 to 8 hours; and one-half to two-thirds of the amount given in the subsequent 16 to 18 hour period. These are calculated from the time that the burn occurred and not from the time of hospital admission. The intravenous fluids are given in half their calculated amount during the second 24 hour period. Meeker[18] advises not giving over 15 per cent of the body weight in intravenous fluids in order to prevent the possibility of congestive heart failure occurring on the third to fourth days, when fluids are being resorbed from the tissues.

The colloid used should consist entirely of plasma for scalds up to 30 per cent of the body surface; whole blood and plasma in a 1 to 2 ratio for flame burns up to 30 per cent or scalds over 30 per cent; and whole blood and plasma in 1 to 1 ratio for flame burns over 30 per cent[19].

Potassium may be added to intravenous fluids after good urine output has been established.

There has been recent controversy concerning the nature and amount of fluids for burn cases. Metcoff[20], *et al.*, resorted to excellent balance studies and analysis of burn tissue fluids[21]. They found that the standard rules, as given above, gave excessive amounts of sodium chloride and nitrogen with insufficient amounts of potassium. Although these investigators believe that burn patients are receiving poor electrolyte fluid therapy, it would be unwise to discard the old rules that have given fairly satisfactory results in previous years until a simplified new set of rules has been evolved for general use.

While the best indicator for adjusting the administered fluids is the clinical condition of the patient, it is necessary to follow the blood pressure, hemoglobin, urine output, and specific gravity[16]. As seen in Table II, these parameters can indicate which fluid changes might be necessary. For example, if the child has a decrease in his blood pressure, hemoglobin and urine flow, and an increase in urine specific gravity, blood should be administered.

TABLE II

B.P.	Urine Flow	Urine sp.g.	Hgb.	Change Indicated
N.	Dec.	Inc.	Inc.	Speed up D/W
Dec.	Dec.	Inc.	Inc.	Speed up plasma
Dec.	Dec.	Inc.	Dec.	Use blood
N.	Inc.	Dec.	Dec.	Slow D/W
Inc.	Inc.	Dec.	Dec.	Slow plasma

This table is modified from Hendren, W. H.: Treatment of the Severely Burned Child, Pediatric Clin. of No. America, 9:283, Feb. 1962.

To follow urine outputs and specific gravities accurately, it is necessary to catheterize the urethra and run the risk of urinary tract infection. In general, normal urine outputs vary from 10 to 15 milliters per hour for the infant to 25 to 35 for the 10 to 12 year-old-child. The urine specific gravity should be kept below 1.025. Very few burn patients will be involved with true renal shutdown within the first 24 to 48 hours. If the patient appears oliguric after 12 to 18 hours, a test water load of 20 ml/kg. of 5 per cent D/W given within 30 to 45 min-

utes usually produces a diuresis and indicates satisfactory renal function.

Early deaths occur with shock, although some burn patients have had early positive blood cultures, indicating that a fatal septicemia can occur within 24 to 96 hours[22]. The late mortalities occur with Pseudomonas septicemia[22] or as a Pseudomonas superinfection after staphyloccal sepsis[23]. Late infection mortality rate was reduced by half by the use of plasma as the colloid and intramuscular administration of gamma globulin in the children less than 6 years of age who had a 10 to 30 per cent burn[22]. (Gamma globulin dosage - 1 ml/kg. on days one, three, and five.) A similar effect was *not* seen in the age group over 6 years. Early grafting procedures would also seem to offer effective prevention of bacterial invasion through the burned surface[16].

Summary

Highlights have been presented in the pediatric evaluation of the injured child. General immediate care, including external cardiac massage, and initial emergency treatment technics have been summarized. Specific measures such as intravenous urea and hypothermia can be beneficial in the care of the patient with the head injury. The judicious use of blood and intravenous fluids in the case with hemorrhage, the anuric patient, and the burned child is essential for good treatment. Continued critical evaluation of old and new methods by the surgeon and pediatrician together will enable them to save more of these children.

A bibliographic listing of 23 citations appears in Dr. Kushnick's reprints.

Seton Hall College of Medicine

Lollipops for Good Boys and Bad Teeth

Regular lollipops are the dread of conscientious dentists. We know—or should know—about the decay-forming action of sugar lollipops. Yet some physicians (including pediatricians who should surely know better) give them as rewards to little girls and boys. Another group of offenders includes barbers, whose standard equipment often includes a well of sugar lollipops as bait to keep Butch quiet while he gets his butch. Since we can't be against lollipops, or against rewards for good little girls and boys, the best we can do is to suggest sugarless pops.

These look, smell, and taste like the standard caries-encouraging commodity; but they don't add to a child's dental miseries. Maybe if each doctor tried to persuade *his* barber to install sugarless pops in the container, the next generation might be able to cry "Look, Pop, no cavities!".

The Illusion of Absolute Safety

We must consider drug safety, not as an afterthought to tragedy, but as an integral element of scientific advance. We must be carefully safe, but we can never be absolutely safe. There is some risk attendant on the acquisition of knowledge and its application.

The future calls for a greater emphasis on the means whereby the results of our enormous investment in health research can be applied. The counterparts of insulin, pamaquine, digitalis, or even common salt in babies' formulas can be dangerous if improperly used.

—Lowell T. Coggeshall, M.D., to National Academy of Sciences, April 9, 1963.

Telling the patient what medication to buy is an invitation to misunderstanding.

Telephoning of Prescriptions

Irving Rubin,* Ph.G.
Manhasset, New York

It's 9 p.m. A physician's phone rings. A patient reports that she has a cough but that her temperature is normal. Her request: "Can you tell me what medicine I can take now, doctor? I'll probably see you tomorrow."

This situation—and many others like it—brings up this question: Should the physician give drug information orally to the patient?

A just-completed national survey—conducted among pharmacists by *American Professional Pharmacist* magazine—concludes:

"In the interest of the patient's health and safety, the physician should write prescription orders. If he must phone, then he should telephone a pharmacist."

Six specific reasons were given:

1: One of the problems encountered is *sound-alike* names of drugs. For example, when the patient is given the name of a drug, the patient too often misspells or mispronounces it—when relaying it. As a result, the patient can actually take the wrong medicine, or not get it at all, because the pharmacist cannot interpret the request. And in one famous malpractice action, the patient heard the doctor advise "bichloride of mercury" when he actually advised "mild chloride of mercury." As Confuscius has said, "Whatever *can* be misunderstood *will* be misunderstood."

2. Drugs are available in several forms and dosage strengths. Although the patient may have the correct name of the drug, she may not remember the form or the strength. As a result—because she is too embarrassed to phone the physician again—the patient may not even obtain the medication.

3. A patient may forget the dosage you called for. More often she will forget the instructions. You may have said "three times a day." She may remember it as "every three hours."

4. Even if the patient correctly remembered all these, it might turn out to be an "Rx only" drug. The pharmacist is unable to sell it without a prescription. The patient may then become angry at the physician.

5. When the patient knows the name of a drug, she might—as a special "favor" to a friend—suggest that the friend take the medicine for a "similar condition." This potentially-dangerous, patient-to-patient "diagnosis" is *unlikely* to occur if the prescription is written.

6. A prescription given orally to a patient eliminates the exact written Rx record—stored at a pharmacy. This record might be a life-saver if a malpractice action looms.

Written prescriptions are in the best interest of both the public and the physician. Aside from preventing errors, a written prescription will generally avoid delay in getting the proper medication to the proper patient at the proper time.

When medication is to be prescribed—pursuant to a phone call or even during an office visit or house call—a *written* prescription is advisable. In the rare situation where a written Rx is inconvenient or impossible it would be best for the physician to say to the patient: "What is the phone number of your pharmacist? I will phone a prescription to him." Or perhaps he can say: "Please ask your pharmacist to phone me."

Drug orders, therefore, are best communicated directly from the physician to the pharmacist—whether the communication be *via* a written prescription or *via* the telephone.

1447 Northern Boulevard

*Mr. Rubin is editor of *The American Professional Pharmacist.*

Dr. Wood here offers a guide that will enable any school physician or pediatrician to organize a hearing screening program.

The Screening of Hearing In School Children*

William L. Wood, M.D., Red Bank

The major goal of hearing screening in schools is the early identification and prompt medical direction of children with impaired hearing. About five per cent of every school population has a hearing problem of some kind. Ignored during the early stages, this may lead to permanent irreversible hearing loss. Of this five per cent with hearing loss many will respond to medical treatment if treated early enough. Some will spontaneously regain normal hearing. An estimated one per cent, however, will have permanent and irremediable hearing loss of a handicapping nature. They will require special educational services. The purpose of hearing testing is to discover which children, because of hearing difficulties, are in need of special medical or educational attention.

Hearing testing as conducted today is often inadequate. The program is only as good as its equipment and testers. With adequate equipment and trained testers, valid results will be obtained and unnecessary referrals avoided. It is important, therefore, to have adequate control testing apparatus with periodic calibration. It is also essential that it be staffed by testers trained to use this equipment accurately.

The testing apparatus recommended is a Puretone® Audiometer. This electronic instrument produces controllable frequencies and intensities of puretones that are used to measure ability to hear. School nurses, teachers, or principals should be trained in the art of giving a Puretone® Audiometer test.

It is impossible to test every child each year. We suggest, therefore, that the child be tested at intervals of three years with the primary, third, sixth, ninth, and twelfth grades tested each year with provisions for retesting any child suspected of having (or indicated by records as having) a hearing loss. Most children with hearing impairments will be found in the primary grades. If it is necessary to slight any part of the school population, the lower grades should never be neglected.

The first step is to screen as many children as possible. This involves division of the children into those who have normal hearing and those with some degree of hearing loss. No attempt is made to determine how much hearing loss a child may have during the screening. A child failing the screening test should be referred for an otologic examination. Test each child individually in a small quiet room. Considerable time may be saved by having the children brought into the room in groups of four, five, or six. This makes it unnecessary to repeat the instructions to each child, thereby minimizing the time lost between tests. The testing is initiated by telling the child that you want to find out how softly he can hear buzzing and whistling sounds. He is instructed to indicate in some way as he hears the sound.

The traditional method of screening is the "individual sweep test," sweeping through the frequencies on a Puretone® Audiometer at a fixed intensity level testing frequencies 500, 1000, 2000, 4000, 6000, and 8000 CPS. There have been many modifications, changes, additions, and subtractions to the traditional method of sweep screening.

*Read at Atlantic City on May 15, 1963 at the Annual Meeting of The Medical Society of New Jersey.

A modification of the traditional screening test (and one that we recommend for the general use in our school system because of its simplicity, speed, uniformity, and accuracy) is the two-frequency method of screening. We test the 4000 and 1000 CPS frequencies at the 15 decibel intensity level. Glorig and House[1] reported from an extensive review that the 4000 CPS frequency consistently tended to show the greatest hearing loss of any frequency in the low tones. From their investigation they concluded that a screening test can be conducted at 4000 CPS at 15 decibels with a high degree of accuracy and a considerable saving of time. Later[2], they suggested that the accuracy of the screening test could be increased—almost to one hundred per cent—by using two frequencies instead of one. To reduce the number of false positives and avoid unnecessary referrals, they added the 2000 CPS. If a child failed to hear 4000 CPS at the 15 decibel level he was tested at 2000 CPS. If this were heard no further testing was necessary. Mendune and Sataloff[3] verified Glorig and House's contention that the 4000 CPS showed the greatest hearing loss in the low frequency range. Testing the 4000 CPS at the 15 decibel level they found that only five per cent of the one hundred cases would have been missed. They reported five per cent false negative using this criterion.

However, when the 2000 CPS was added to reduce the number of false positives the false negatives were increased from five per cent to nineteen per cent. Substituting the 1000 for the 2000 CPS, no false negatives were reported by Sataloff and Mendune[3] in their group. On the basis of these results the 4000 and 1000 CPS appeared to be the frequencies of choice and proposed for screening frequencies for sweep testing in the school children.

The two frequency technic can be used with any audiometer by testing the 4000 and 1000 CPS at the 15 decibel level. The test is done by introducing each frequency at the 35 decibel sensation level, producing a tone which most children can easily hear. This is in preparation for listening to the tone which will be presented at the 15 decibel testing level and then testing each ear at the 15 decibel level.

Children responding correctly at the 15 decibel level of the frequencies tested are considered to have normal hearing. A child fails the Sweep Test if he is unable to respond to either frequency at the 15 decibel level and is given a follow up Puretone® Threshold Screening Test.

The Threshold Screening Test measures the child's threshold at each of the standard audiometric frequencies. It is the lowest sensation level at which the child can correctly respond to the presence or absence of tone. This is recorded on an audiogram and will show the amount of hearing loss the child has in each ear at each frequency.

The test is initiated by turning the machine on with the frequency dial set at 250 CPS and the intensity level at 35 decibel. If the child hears, turn the tone off and decrease the intensity by 10 decibel. If the subject continues to hear, repeat this procedure by decreasing the intensity by 10 decibel steps until the child indicates the tone is no longer heard. Then increase the intensity by 5 decibel steps until he again hears the tone. This represents the screening threshold for that particular tone. Repeat this procedure testing tones 500, 1000, 2000, 4000, 6000, and 8000 CPS. Then test the other ear in the same manner.

A loss of 20 decibel or more at any two frequencies in either ear or 30 decibel or more at any single frequency in either ear is generally considered medically significant. This child fails the diagnostic puretone threshold examination, and the family is notified by a copy of the report to physicians and parents. These children shall then be referred through the family to a physician for a complete otologic and audiometric examination. The physician is then asked to complete the report to parents and physicians. This is returned to the school. The school nurse gets in touch with the family if the completed report is not received within six weeks after notification.

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[1]Glorig, A and House, H.: Archives of Otolaryngology, 66:228 (August 1957)

[2]Glorig, A. and House, H.: Journal of the American Medical Association, 166:1719 (April 1958)

[3]Sataloff, J. and Menduke, H.: Archives of Otolaryngology, 70:624 (Nov. 1957)

Summary

A hearing screen program is developed (a) to afford early identification of children with hearing impairment; and (b) to see that such children get prompt medical attention and direction. In the first twelve grades, every child should have a screening test at least once every three years. For "sweep screening" the two-frequency pattern is suggested, using 1000 and 4000 CPS at the 15 decibel intensity level. A threshhold accuracy test is done with children who fail the "sweep" test. If hearing loss is suspected, a report is sent to the physician with a copy to the parents. The hope is that the family or their physician will then arrange for prompt and complete otologic study.

258 Broad Street

Misdiagnosis Can Be Fatal

Dr. Harry L. Mueller of Boston reports this one. It was distributed in the newsletter of "The International Correspondence Society of Allergists."

A young couple had dinner with friends. Upon leaving, the man took his coat from the warm closet which is a favored habitat of the paper wasp. As he put his arm through a sleeve of his coat, he felt a scratch at his right wrist. Five minutes later, as he and his wife were driving away from the house, he told his wife that he thought he had indigestion. Shortly after that, he stopped the car just before he lost consciousness. His wife drove him to the community hospital less than a mile away. The nurse on duty in the emergency room called the physician on duty to notify him that she had a moribund man with a heart attack. When the physician arrived, the patient's pulse and blood pressure were unobtainable but he noted swelling of the right forearm and urticaria at the chest. He decided that this was not a heart attack but some sort of anaphylactic reaction! Without benefit of history, he gave epinephrine. His patient recovered in a short time. Later, it was shown that this man was stung by a paper wasp which had found a happy home in his coat sleeve. Many of these fatalities are hard to run down and go unrecognized.

A bracelet or disc with the legend, "Allergic to insect sting," would have provided this hard-pressed physician with accurate and rapid orientation, since he had had a similar milder reaction. The patient, on the other hand, ceases to gamble with his own life.

Osteopetrosis and Osteogenesis Imperfecta

Patients with either of the above disorders will be welcomed at the National Institutes of Health in Bethesda, Maryland, under certain conditions. They must be between the ages of 21 and 51, in good general health, and specifically free of renal or gastro-intestinal diseases. Only ambulatory patients are acceptable, and they should plan to remain at the hospital from 20 to 30 days.

Upon completion of the study, the patient will be returned to your care, with a complete summary.

If you have any patients who might fit into this project, get in touch with Metabolism Service at the National Cancer Institute, National Institutes of Health, Bethesda, Maryland 20014.

STATE ACTIVITIES

Trustees' Minutes

November 17, 1963

A regular meeting of the Board of Trustees was held on Sunday, November 17, 1963, at the Executive Offices. For the full information of the membership, detailed minutes are on file with the secretary of each component society. A summary of the significant actions follows:

Workmen's Compensation . . . At the request of the Division of Workmen's Compensation of the State Department of Labor and Industry, established a Medical Advisory Committee to the Workmen's Compensation Division, as follows: Marcus H. Greifinger, M.D., Chairman; Joseph A. Lepree, M.D.; and Andrew C. Ruoff, III, M.D.

Supreme Court Committee . . . At the invitation of the Supreme Court, authorized the President to appoint a committee corresponding to that recently set up by the Supreme Court, "to continue the work previously done by its Advisory Committee on Impartial Medical Examinations and Expert Testimony, and to expand the area of interest to include the mutual problems of the court and the medical profession generally."

GHI vs. Howell . . . Received the report of Legal Counsel, as follows:

The appeal hearing commenced on October 28, before the Commissioner of Banking and Insurance in the Assembly Chamber, State House, Trenton, and continued on October 29, in the Passaic Court House, Paterson. At Mr. Backes' request, the hearing will continue on November 19, in the Board Room of the Rahway Hospital, at which time Dr. Lance will testify to combat previous adverse testimony which Mr. Backes felt was damaging. The next step after November 19, assuming the hearing will terminate on that date, will be for each party to submit briefs with the appellant submitting his first. The case will probably not be re-argued before February or March of next year.

Hospital Bylaws . . . Directed that the following communication be sent to Presidents of all New Jersey hospital medical staffs, with copies to component societies' secretaries and executive secretaries:

The Board of Trustees of The Medical Society of New Jersey, at its November meeting, lengthily considered numerous inquiries from members as to how hospital bylaws might be amended, in consequence of the Greisman case, so as to eliminate any possibility of discrimination against individual applicants and to continue to protect the public interest.

The Board recognized that, in view of the decision in the case of Greisman vs. Newcomb Hospital, hospital bylaws can no longer require membership in a county medical society as a necessary qualification for staff membership.

It unanimously agreed that, in its opinion, the following substitute requirement should be utilized:

"An applicant for a staff position must be a member of that professional society or association in which his doctoral degree entitles him to hold membership."

The foregoing requirement, in the Board's opinion, would be valuable:

1. to hospitals, by reason of the fact that the qualifications of applicants for staff positions will all have been fully investigated and cleared by the credentials committees of the professional societies, as part of their procedure of admission to membership; and

2. to the public, by reason of the fact that membership in professional societies would insure to the public that hospital staff members are subject to, and controlled by, not only the exactions of civil law, but also the exactions of codes of ethical conduct and standards of professional deportment.

General Practice . . . Appointed a special committee to implement the suggestion of the AMA that the need for general practitioners be emphasized, as follows: Charles H. Calvin, M.D., Chairman; Joseph R. Jehl, M.D.; and Louis K. Collins, M.D.

Polio Immunization . . . Investigated a report from the State Department of Health on the status of the mass polio immunization campaigns.

Sixteen county medical societies have agreed to sponsor campaign programs:

Campaigns completed — June 1963 — Burlington County

Two feedings completed — September 22 and October 27, 1963—Camden County
One feeding completed—October 27, 1963—Cumberland, Gloucester, Salem, and Warren Counties

Campaigns planned:
Initial feeding—December 8, 1963—Cape May, Hunterdon, Mercer, Monmouth, Ocean, and Somerset Counties
Initial feeding—January 19, 1964—Atlantic (tentative), Middlesex (tentative), and Morris Counties
Initial feeding—March 1964—Sussex County

The Department has no knowledge of any firm plans for countywide campaigns in the five northeastern counties—Bergen, Essex, Hudson, Passaic, and Union.

. . . Recommended that the component societies of Bergen, Essex, Hudson, Passaic, and Union "establish a contact or have a conference of their representatives to explore the possibility of working individually or collectively in planning programs in their counties."

King-Anderson Bill . . . Received the official statement, over the President's signature, which was filed for inclusion in the printed record of the hearings on H.R. 3920 (King-Anderson Bill).

AMA Delegates . . . Received the report of the AMA Delegates that Dr. Isaac N. Patterson of Westville will represent the New Jersey delegation on a special committee appointed to review the make-up and function of the AMA House councils and committees.

Union County Resolution . . . Approved in principle the following resolution, which was forwarded to the Joint Commission and to the AMA:

Whereas, the Board of Governors of Muhlenberg Hospital, Plainfield, New Jersey, has by its unilateral action imposed on the staff a new set of By-Laws to be effective January 1, 1964; and

Whereas, these new By-Laws abrogate many long-held and cherished rights, the most highly valued of which are the right to elect the Chief of Staff and Chiefs of Departments, the right to recall officers of the staff and revoke their acts, and the right to amend the By-Laws of the staff; and

Whereas, the staff at its regular meeting on September 24, 1963, voted overwhelmingly to reject these new By-Laws and to take further positive action (to prevent their implementation);

Therefore Be It Resolved, that the Medical Board of Muhlenberg Hospital addresses itself to the Joint Commission on Accreditation of Hospitals and the American Medical Association, together and separately, to implore them to intervene on behalf of the medical staff of Muhlenberg Hospital, Plainfield, New Jersey, in its differences with its Board of Governors.

Dual County Practice . . . Accepted the report of Dr. John J. Bedrick and Dr. Thomas C. DeCecio, who were appointed "to investigate the problem of membership of physicians who open a second office in another county where the second county society requires transfer of membership before hospital privileges in that county will be granted":

. . . the problem stems from the bylaws of some hospitals which require that a physician be a member of a specific county medical society before staff membership will be granted. Change in hospital bylaws is the solution to the problem, and both expressed the opinion that acceptance by hospitals of the Board's opinion on staff membership (reported above) is the solution.

Albert B. Sabin, M.D. . . . Nominated for honorary membership in MSNJ Dr. Albert B. Sabin, developer of the oral polio vaccine, who graduated from Paterson High School in 1923.

Hospital Advisory Council . . . Nominated Doctor Blaisdell of Asbury Park for re-appointment to the Hospital Advisory Council of the State Department of Institutions and Agencies.

December 15, 1963

A regular meeting of the Board of Trustees was held at the Executive Offices in Trenton on December 15, 1963. A complete set of the minutes of the meeting is on file in each county society. A summary of the significant actions follows:

GHI vs. Howell et al . . . Commended Dr. Elton W. Lance of Rahway for his time and effort in preparing for his appearance at the hearings.

Package Insurance Program . . . Accepted Counsel's report that he had reviewed the new package insurance coverage and had found it more extensive than that previously held by the Society.

Dr. William F. Costello . . . Commended Doctor Costello of Dover—whose term expires on December 31—for his 17 years' service as an AMA delegate.

Major Medical Insurance . . . Approved the following report of the Committee on Medical Defense and Insurance:

(1) *Loss Ratio - Rate Increase* . . . In July 1963, the loss ratio for the first 6 months of 1963 was running in excess of 100 per cent for the major medical program. Under date of November 5, 1963, Mr. Blanksteen reported that, due to rising hospital costs, the loss ratio for a 7 month period was 132 per cent, without provision for reserves for claims incurred during that period but not yet reported to the company. With the addition of two hundred plus impaired risks to the plan (by virtue of the statewide qualification in enrollment) the loss ratio will be further adversely affected.

He advised that, in view of this trend, and to keep the program on a sound fiscal basis, the home office

has directed a premium rate increase of 50 per cent, effective March 1, 1964, and that notice of the increase will be given now to the policyholders. The new premiums have been approved by the State Commissioner of Banking and Insurance.

Mr. Blanksteen reported that, despite the company's overall poor experience with the major medical policy, he has succeeded in obtaining a provision that will permit continuance of the policy in force for a widow (and her dependent children) until the time she remarries. Up to now the policy could not be carried on for a widow of a deceased society member policyholder after the anniversary date of the policy to which premium had been paid. The endorsement has been submitted to the Department of Banking and Insurance, and approval is anticipated.

(2) *Fee For Forms* . . . One of the attending physicians in the above-mentioned case had billed the insurance company $10 for filling out the questionnaire-inquiry which the company paid. It was felt that a fee of $5 for filling out insurance and claim forms—as recommended by the AMA in association with the American Bar Association—was fair, and that any higher fee was uncalled for except in unusual cases.

Insurance Coverage . . . Suggested that county insurance committees refer to the state Committee on Medical Defense and Insurance all questions concerning coverage and procedures under the insurance program, so that required hearings may be conducted at state level; and that Mr. Blanksteen and Mr. Britton be requested to refer to the state committee any requests for appearances before county committees.

Aged and Tuberculosis . . . Adopted a recommendation that members in their general physical examinations of elderly individuals do routine x-ray tests to rule out tuberculosis.

Rehabilitative Services Directory . . . Approved the recommendation of the Council on Public Health that the Committee on Rehabilitation start collecting information needed for a directory of rehabilitative services and facilities in New Jersey.

Cigarette Smoking and Lung Cancer . . . Adopted the following resolution and directed that it be released in the general press:

Whereas, there is definite statistical and apparent scientific evidence that lung cancer is more frequent in cigarette smokers than in non-smokers; and

Whereas, The Medical Society of New Jersey lists as one of its constitutional purposes "to promote the betterment of public health; and to enlighten and direct public opinion in regard to the problems of medicine and health for the best interests of the people of New Jersey"; and

Whereas, the increasing incidence of fatal lung cancer is undeniably one of the pressing health problems of our day; now therefore be it

Resolved, that The Medical Society of New Jersey call upon the people of New Jersey to recognize the intimate connection between sustained cigarette smoking and lung cancer, and encourage:

1. those individuals who do not smoke cigarettes never to initiate the habit of smoking; and

2. those individuals who do smoke cigarettes to abandon, or restrict, their indulgence.

Dr. Albert B. Sabin . . . Recommended that the nomination of Dr. Sabin for honorary membership in MSNJ be approved and be officially transmitted to component societies at least three months before the 1964 annual meeting.

Retirement Plan for Physicians . . . Recommended that determination of the best plan for MSNJ members "be referred back to the special committee for further study, and be taken from the table when the situation is clarified . . . that a communication be sent immediately to the members" explaining the Board's action, as follows:

On November 24, 1963, The Medical Society of New Jersey's Committee on Retirement Plan for Physicians approved two plans: (A) the Mercer County Medical Society's Plan through Mutual of New York; and (B) Bankers' National Life Insurance Company of Montclair Plan. Each was recommended to the Board of Trustees on December 15, 1963, for consideration in determining the best plan for MSNJ members.

The Board of Trustees chose to table the matter. This action arose from the conviction that adoption of any plan at this time would be premature, and the following reasons are the basis for the Board's action:

1. The Mercer County Plan has not as yet been approved by the Internal Revenue Service.

2. The Bankers' Life Plan has been temporarily withdrawn in view of that company's connection with the AMA Plan though affiliation with Scudder, Stevens and Clark.

3. At least one plan approved by IRS and SEC (AMA or individual) is currently available to members.

4. Further study must be given to all of the considerations necessary to determine the best plan to be submitted, in the name of MSNJ, for approval by IRS.

5. The benefits to be derived today from any plan are minimal; in fact, there appears to be no benefit to any physician employing more than one person.

6. The burden on MSNJ in securing IRS approval is real and should not be undertaken in contemplation of future change, since any approved plan must be designed as permanent in nature.

7. Anticipated federal legislative changes, perhaps even in 1964, will improve the benefits available under a plan subsequently approved and might necessitate the redoing of a plan approved prematurely.

8. Before any member decides to participate in any plan, it is recommended that he consult with, and seek the advice of, his attorney and/or accountant, or both.

County Medical: Keystone of Medicine

The doctor's basic membership is in a county society. Here is, in a real sense, his "own" organization—where he can know almost everybody. Here he can rise to leadership. Civic activities sponsored by county societies ring the bell more effectively than those developed by larger units.

Last year, the AMA Council on Medical Services provided a searching study of the anatomy of the nation's county medical societies. These data are drawn from that survey. Some 1800 counties are represented among 1200 societies that responded to the AMA questionnaire. Of these, 272 were "district" or multi-county societies; the remaining 930 represented as many different counties.

Until recent times, the county meeting was the prime source of a doctor's graduate education. Before World War II, a typical society would hold nine or ten meetings a year with a scientific program at each. Over a 30-year professional career, a faithfully attending physician would have heard 200 to 300 scientific programs. During the past two decades, hospital staff sessions, formal graduate courses, and the burgeoning of specialty societies have decreased the educational role of the county society. Some, indeed, have abandoned scientific programs and concentrated on administrative, medicolegal, economic, and legislative problems. In general, the larger societies (500 or more members) found social-economic topics better drawing cards, while scientific programs were more attractive in smaller societies. The best attention-getters were well-known speakers, usually drawn from a distance. Moving picture films were effective attendance-persuaders only in the smaller societies. (In only one of the 1200 societies were tape recordings found to outdraw live speakers or films.) Attendance tends to be inversely proportionate to the size of the society. Before World War II, most societies could report that half or more of their members came to each meeting. This figure went into a tailspin after the war—probably because of competition with hospital staff meetings and specialty societies. Modal attendance records in 1962 were:

Size of Society	*Modal Attendance*
Fewer than 15	95%
16 to 49 members	85%
50 to 99	70%
100 to 299	35%
300 to 499	25%
500 to 1499	15%
over 1500 members	9%

More than 500 of the 1200 societies have emergency medical call plans in operation. All of the larger (over 1500 members) societies, and more than 80 per cent in the 500-to-1500 member size, maintained such services. On the other hand, collection agencies were unpopular. Some 10 per cent of all county societies operate such plans. Between 20 and 35 per cent of the societies maintain medical libraries—the larger the association, the more likely that it had a library. In larger cities, there may be good library facilities in hospitals, specialty societies, or academies of medicine; in small societies, doctors often have an informal book-loan plan among themselves.

Fee schedules and committees to fix fees are not especially popular. About 80 per cent of the county associations have no such program. This activity—or lack of it—bears no relationship to the size of the society. Insurance programs on the other hand were common. Of larger (over 500 members) societies, about three quarters sponsor accident, health, and/or life insurance. On the other hand, fewer than a third of the larger societies (and only 7 per cent of *all* county societies) sponsored professional liability insurance.

One interesting table analyzes county society dues. In 1963, *state* society dues averaged $57 and AMA dues $45. The range of *county* society dues was vast: $1 a year to $350. For smaller societies, the median figures $15 to $25; for larger county associations, $35 to $50 a year. Of the 60 largest county medical societies, 53 employed full-time, salaried executive officers.

LETTERS TO THE JOURNAL

Dear Sir:

In a timely article on the cancer cell (this JOURNAL, September, 1963), Dr. Howard B. Miller refers to a private communication from me as biochemist for a municipal cancer research division. I was the latter's pathologist as well as an "attending" in a municipal hospital's cancer therapy service at the time of this communication. Certain amplification of Dr. Miller's points, attributable to me, does not flow entirely from biochemical esoterism.

The tritiated thymidine technic for measuring the rate of DNA synthesis was not used by me. Published results from world-wide sources now indicate for every autochthonous human cancer a cell division rate materially *less* than that of normal homologous cells of origin. This is confirmatory of my prior conclusion on the basis of "information theory" analysis of the cancer cell's DNA that the latter's entropy would be too high to permit as rapid cell division as was occurring in the cells of normal somatic and germinal tissues. I also told Dr. Miller (whose manuscript I read prior to publication) that some reservation must be made about that series of "anti-cancer" cytotoxic, radiomimetric, purine and pyrimidine analogue and antifolic drugs which he proceeded to describe because all were designed, and actually do inhibit, DNA synthesis either directly or indirectly. I tried to relay my alarm as a physician over a possible therapeutic fallacy in continued being. I felt it important that implications about the propriety of cytotoxic chemotherapy arising out of newer knowledge of the behavior of cancer cells be placed before practicing physicians. I believed that Dr. Miller might do this better in the JOURNAL than I could in the very specialized communication media of my own normal scientific habitat.

I am not alone in my concern over the fact that the cytotoxic drugs do exactly what they were designed to do: inhibit DNA synthesis of rapidly dividing cells. They therefore could more seriously affect normal tissues than their presumed target. Fortunately, this is getting some popular attention. At the recent meeting of the International College of Surgeons, Dr. Abraham Oppenheim (director of the division in which I work) amplified this point both from the tritiated thymidine-uptake results and from the thermodynamic considerations which I am supposed to have contributed. As it turns out, I have no priority here, either.

In the last connection, attention should be directed to a series of papers, "A Concept of Cancer" by Dr. G. E. Loxton, in the British Medical Press running through the 1959 issue. If I was guilty of having overlooked them for three years it is hoped that others concerned will not be similarly remiss.

Dr. Loxton's closely reasoned and beautifully styled essays (from which the long-sought *definition* of cancer could very well emerge) gave my ego a considerable jar. He apparently had used entropy and energy considerations, and had published his conclusions before my own group had even commenced our analysis of these same considerations. Our studies had the underwriting of an "accredited" cancer agency. Like most "recognized" cancer research, it was paid—directly or indirectly—from the taxpayer's pocket. I had batteries of biochemists, biophysicists, cyberneticists, mathematicians, and statisticians (all paid from public funds) to assist and this project cost a little more.

My feeling about Dr. Loxton were not ameliorated when I went to inquire about him at the agencies who keep dossiers on "acceptable" cancer researchers. None had ever heard of him. It turns out that he was a practicing general physician while writing his opus. Ostensibly, his contribution cost the British taxpayer not one farthing. I have never met him but we do, of course, now correspond. I find this correspondence helpful, whereas he seems to be quite amused and surprised about all the fuss. It turns out, also, that he has a busy practice and just wants to be otherwise helpful.

ROBERT B. BARNARD, M.D.
Lakewood

OBITUARIES

Dr. Charles H. Evans

Death came suddenly to Dr. Charles Hawes Evans on December 12, 1963. He died at the Orange Hospital Center where, for some time, he had been chief of surgery. Dr. Evans was born in Virginia in 1897. He was a 1925 graduate of its University Medical School. After interning in Richmond, he came to New York for residencies in gynecology at the Postgraduate Hospital and obstetrics at the New York Lying-In Hospital. On completing his residencies, he opened an office in East Orange for the private practice of surgery, gynecology, and obstetrics. In 1933 he became affiliated with the surgical staff of the Orange Hospital Center, serving the institution in all grades, finally becoming a surgical chief there. He was also associated with several other hospitals in Essex County.

Dr. Evans became a diplomate in general surgery. He was active in our Essex County Medical Society and a trustee of the Pierson Medical Library. He was known nationally as a philatelist. He was also a fellow of the American College of Surgeons.

Dr. F. Richard DeVincenzo

At the early age of 51, Dr. F. Richard DeVincenzo died on Christmas Eve 1963 in Hoboken, the town where he was born. A 1936 graduate of Georgetown University's Medical School, Dr. DeVincenzo interned at St. Mary's Hospital in Hoboken and, after a brief period of general practice, devoted himself exclusively to gastro-enterology. He was consulting gastro-enterologist to the Hudson County Hospital for Mental Diseases in Secaucus, and chief of the gastro-enterology section of the Medical Service at St. Mary's Hospital in Hoboken. He was also a Hoboken school physician and was active in committee work for the Hudson County Medical Society.

Dr. Ronald Harner

On November 25, 1963, Dr. Ronald Harner died after a long illness. Born in Pennsylvania in 1906, he received his M.D. at Temple in 1928. Dr. Harner did general practice in northern Hunterdon County, with his office in High Bridge. He was active in the affairs of the Hunterdon County Component Medical Society. During World War II, he was on active duty in the Medical Corps of the Army of the United States, seeing service in Africa and the Middle East.

Dr. Beulah Hollinshed

At the grand old age of 84—and at the end of a long, fruitful, and useful life—Dr. Beulah Hollinshed died at her home in Westville, Gloucester County, on November 22, 1963. She was a 1907 graduate of the Women's Medical College of Philadelphia. In 1957 Dr. Hollinshed received the Golden Merit Award of The Medical Society of New Jersey. Until her retirement in 1958, she was active in committee work with the Camden County Medical Society. She then became an emeritus member of that society.

Dr. Edgar Lane

Dr. Edgar Winslow Lane, one of our State's senior physicians, died in Florida on November 30, 1963. He was 75 years old at the time of his death. Dr. Lane was born in North Carolina during the presidency of Benjamin Harrison. He received his M.D. in 1915 at the University of Maryland. After interning in Baltimore, he came to New Jersey to serve as a House Physician at Glen Gardner, and this brought him to Hunterdon County—an area he served devotedly for a third of a century thereafter. In 1918, he opened his office for private general practice in Bloomsbury. He served on the staffs of several hospitals in Warren-Hunterdon area, and from 1933 to 1952 was chief of staff at the Warren Hospital in Phillipsburg. He was vice-president of the Citizens' National Bank in Bloomsbury.

Dr. Kenneth MacAlpine

One of Camden County's best known obstetricians and gynecologists died on December 5, 1963 with the passing that day of Dr. Kenneth Brown MacAlpine at the untimely age of 58.

A 1930 M.D. graduate of the University of Syracuse, Dr. MacAlpine interned at the Cooper Hospital in Camden. He did graduate work in obstetrics and gynecology and, after a brief general practice experience, he limited himself to that specialty. He was a Fellow of the New Jersey Obstetrical and Gynecological Society and on the obstetrical service at Cooper Hospital. He was active in the affairs of our Camden County Component Society.

Dr. Thomas H. Mahoney

Dr. Thomas Howard Mahoney, a young and active Bergen County urologist, died on November 26, 1963 at the untimely age of 53. Born in New York City, Dr. Mahoney received his M.D. degree at the University of New York's Downstate College (Long Island) in 1942. He then joined the medical corps of the Army of the United States and subsequently became a resident in urology at St. Mary's Hospital in Passaic. He subsequently became affiliated with the staff of that hospital and with the Long Island College Hospital in Brooklyn.

Dr. William F. Matthews

One of Montclair's pioneer pediatricians, Dr. William F. Matthews, died in Mountainside Hospital (where he had been chief of staff) on November 15, 1963. Born in Virginia in 1898, he was a graduate of the Medical College of Virginia (class of 1924). After interning in Richmond and serving a pediatric residency in New York, he came to Montclair where he entered private practice. He served the Mountainside Hospital in all grades, from clinical assistant to director of the department of pediatrics there. Dr. Matthews was a diplomate of the American Board of Pediatrics. He had a tour of duty as president of the Associated Physicians of Montclair and Vicinity. Twice he was president of the New Jersey Section of the American Academy of Pediatrics. He also for a time was chairman of the pediatrics advisory committee of The Medical Society of New Jersey.

Dr. Frank H. Pinckney

Dr. Frank Huger Pinckney, often thought of as the dean of the Morristown Memorial Hospital, died on November 27, 1963 at the age of 75. A 1911 medical graduate of the University of Pennsylvania, he served his internship at the Johns Hopkins Hospital in Baltimore. He went into private practice in Morristown, later in Convent, and did general surgery at the Memorial Hospitals in both Newton and Morristown. He became chief of surgery at the latter hospital, and later president of the medical staff there. An FACS, he was active member of the Morris County Medical Society.

Dr. Archie Sofman

Dr. Archie Sofman, one of our state's best known psychiatrists, died in New York on December 23, 1963. Born in Newark in 1909, he received his M.D. degree from the University of Lausanne, Switzerland, in 1938. He did graduate work in psychiatry in Austria following his internship in 1939-40. After several years of military service, he came to Newark and set up an office for the private practice of psychiatry. In 1953 he moved to Westfield, continuing his private practice there. He was one of the senior attending psychiatrists at the Diagnostic Center in Menlo Park. Between 1941 and 1950—except for time out for Army service—he was a resident, later a staff psychiatrist, at Greystone Park. He also served as psychiatric consultant to the New Jersey State Police.

Dr. Albert Van Eerde

Passaic county lost one of its senior physicians and a pioneer practitioner on December 14, 1963 with the death that day of Albert Van Eerde. Born in 1887, he received his M.D. at Bellevue in 1912. He had been a general practitioner in Passaic County since 1914 and was the laureate of one of the Golden Merit Awards of The Medical Society of New Jersey. He was a founder, and an early president, of the Hawthorne Rotary Club. For almost half a century he was head of the medical department of Susquehanna and Western Railroad. He also had had tours of duty as police surgeon and school physician. Prior to entering medical school, he was a practicing pharmacist with a Ph.G. degree from Rutgers.

BOOK REVIEWS

Bee Venom, The Natural Curative for Arthritis and Rheumatism. By Joseph Broadman, M.D. New York City, 1962, Putnam. Pp. 220. ($4.95)

This volume of 220 pages could readily be condensed into one or two pages. Nowhere in this book is there any evidence of basic scientific proof (by clinical laboratory procedures, controls, or comparative statistics) which would render this text significant. The author talks of "cures" of most disorders of rheumatic or arthritic origin including other unrelated diseases such as fibrositis. Tuberculosis, syphylis, and gonorrhea seem to be the only three contra-indications for bee venom therapy.

This book is of interest only to show the extent to which some will stretch their imagination to convince themselves about the efficacy of certain venoms, including the stinging of live bees to effect physiologic changes.

Edward E. Seidmon, M.D.

Office Procedures. By Paul Williamson, M.D. Ed. 2. Philadelphia, 1962, Saunders. Pp. 448. Illustrated. ($13.50)

Dr. Williamson states that this book is a kaleidoscopic view of the practice of medicine with the aim of improving "physicianship" and rescuing it from the "wilderness of esoteric and sophisticated knowledge." It is aimed at all who devote part or all of their time to the general practice of medicine.

This is no tasty morsel for the academician. It is a down-to-earth hearty literary meal for the do-it-yourself clinician. The interested physician will be amazed to find in this unusual illustrated text instructions for repair of everything from anus to zygoma. It is so all-inclusive as to exceed reasonable limits of medical responsibility; as when procedures for biopsy of masses in the breast are described as office procedures. For the busy practitioner in large population centers, the book has limited value in this reviewer's opinion. For the physician in rural areas and those who have no hospital facilities in their area of work, this text might serve as a practical reference manual to help recall time-tested procedures.

David Eckstein, M.D.

Synopsis of Genitourinary Diseases. By A. I. Dodson, M.D. and J. E. Hill, M.D. St. Louis, 1962, Mosby. Pp. 384. Illustrated. Ed. 7. ($7.75)

The authors have accomplished their purpose of providing a synopsis of genitourinary tract diseases for the medical student and physician in practice. This classic in urology is now in its seventh edition, which is an indication of its value in medical literature. The discussions of genitourinary tract disease are brief and to the point but they furnish information on the pathology, diagnosis, and treatment of a variety of conditions. The 123 illustrations well visualize the anatomy and pathology of the conditions discussed.

This book beautifully performs the function suggested by its title. It is an asset to anyone needing a concise reference work on urinary tract diseases. R. L. Gerlaugh, M.D.

Practical Pediatric Dermatology. Ed. 2. By M. Leider, M.D. St. Louis, 1962, Mosby. Pp. 437. ($13.75)

Editor's Note: This book was reviewed by both a pediatrician and a dermatologist. The first review is by a pediatrician.

During this age of rapid advances, it is necessary for general practitioner and specialist alike to read much material to keep abreast of medicine. It is, therefore, a pleasure to discover a book written in so pleasant, clear, and descriptive a style that it makes for rapid reading. Dr. Leider makes the subspecialty of pediatric dermatology appealing. He avoids the technical language and detail necessary for reference use by a dermatologist. However, in

skin conditions that pediatricians see frequently, the pediatrician reviewing this book feels that not as much detail as he would like is always presented. The author explains that this book is "not intended as an exhaustive treatise on pediatric dermatology."

The reader must refer to general and specialized texts to gain a more thorough understanding of skin conditions associated with systemic disease. Dr. Leider's photographic illustrations are very good; his tables of classification, description, and treatment are concise and clear.

This is a highly "practical" book for the physician's shelf; and though detail is not always present, certainly more than a bird's eye-view is presented. Dr. Leider must be a wonderful teacher. This is a book for all physicians, not the dermatologist alone.

Milton Prystowsky, M.D.

Dr. Leider's book is not an "invaluable asset," but it is a useful addition to any doctor's library. As the author says, this material represents an approach to each of the dermatologic problems with only casual references to the therapeutic suggestions and clinical opinions of at least equal authorities. The author is correct in stating that encyclopedic references are available for those who wish more information than he includes. However, he could have easily included additional information useful in the clinical consideration of many of the skin conditions without hazarding the classification of his book as encyclopedic. His attempt to simplify the management and understanding of the various conditions has led in many instances to an oversimplification which (in the minds of non-dermatologists, at least) will further lead these physicians away from the concept of cutaneous medicine as the dermatologic specialty has been attempting to develop it. This simplification of the presentations and his desire to infuse his personal conceptions has occasionally led to a "cracker-barrel" type of discourse which could be annoying to some troubled clinician who might be consulting Doctor Leider's book for an immediate helping hand.

On the other side of the ledger, one should say that in the main the book has a pleasant presentation. It makes for light, rapid reading, and for one interested in a brief review of the individual skin conditions, it would make easy reading for a few evenings. The therapeutic tables represent a useful feature. Many of his photographs could be helpful, and some of his differential diagnostic tabulations do serve to refresh the memory. Dr. Leider is a competent dermatologist; and his academic background, together with the obvious considerable effort he has expended in composing this book and correcting it for the second edition, do make his opinions worthy of consideration.

The book is a worthwhile addition to the working medical library with the likelihood that it will often offer assistance to the general practitioner, pediatrician and dermatologist.

Edmond Edelson, M.D.

Clinical Biochemistry. By Abraham Cantarow, M.D. and Max Trumper, Ph.D. Ed. 6. Philadelphia, 1962, Saunders. Pp. 776. Illustrated. ($13.00)

The interdependence of biochemistry and medicine is becoming increasing apparent. The biochemical approaches now being made to the study of different diseases are extremely varied; descriptions of the relevant discoveries are widely scattered through the medical and scientific literature.

This book assembles, relates, and interprets the facts concerning the biochemical disorders that underlie or are associated with human disease. Apart from their importance for a fuller understanding of pathogenesis, many of the findings discussed in this book are also, of course, of practical importance in the management of both medical and surgical patients.

The authors have succeeded remarkably well in filling the needs of the present-day physician who wishes to know more about the clinical applications of modern biochemistry.

Harold M. Bates, Ph.D

ABSTRACTS

ON TUBERCULOSIS AND OTHER RESPIRATORY DISEASES. ISSUED BY THE NATIONAL TUBERCULOSIS ASSOCIATION

FEBRUARY, 1964 • VOL. XXXVII, NO. 2

TRANSTRACHEAL ASPIRATION TO DETERMINE BACTERIAL FLORA OF LOWER RESPIRATORY TRACT

When the oropharynx is bypassed in the search for bacteria in the lower respiratory passages, mixed organisms are seldom recovered, suggesting that patients with symptoms of "chronic bronchitis" seldom harbor bacteria in these passages.

Infection of the lower respiratory tract is receiving increasing attention as a possible cause of chronic bronchitis and emphysema. There is evidence that *Haemophilus influenzae* and pneumococci, organisms said to be the most frequent pathogens in chronic bronchitis, are commonly isolated from the mouth and pharynx of persons who have no respiratory ailment, and that oropharyngeal secretions mask the bacteriology of those expectorated from the lower respiratory passages.

Aspirates obtained at bronchoscopy by ordinary techniques are frequently contaminated with oropharyngeal organisms. To overcome this difficulty, refinements such as the use of a polyethylene tube to protect a retractable cotton swab have been employed at bronchoscopy, and transtracheal aspiration was developed in an attempt to bypass the oropharynx completely.

Cultures Compared

In the present study, a comparison was made of cultures obtained by bronchoscopic swabbing and by transtracheal aspiration in 44 unselected consecutive patients requiring bronchoscopy.

Of the 44 patients, all but two had roentgenographic evidence of pulmonary disease. Prior to examination 14 patients had received antibiotics that might have eliminated pre-existing infection of the lower respiratory tract.

Transtracheal aspiration was performed immediately before bronschoscopy. The trachea was punctured between the cartilaginous rings. A six-inch length of vinyl tubing, sterilized by autoclaving, was inserted into the trachea through the needle, which was withdrawn.

All cultures obtained by both methods were incubated aerobically at 37 degrees centigrade on blood agar plates for approximately 48 hours. In 6 cases (3 by each method) 3 or fewer colonies of organisms were obtained. Since they appeared to be extraneous contaminants, these cultures were included with the negative tests.

The transtracheal method yielded the higher number of negative cultures and, in addition, fewer "single organism" positive cultures. Two patients yielded the same single organism (one a staphylococcus and the other a pneumococcus) by both methods. Only 4 cultures obtained by the transtracheal route yielded mixed organisms as compared with 11 by the other method.

Mixed Organisms Rare

Mixed organisms were recovered so infrequently by the transtracheal route that one suspects that when they are recovered the tip of the vinyl tube had been coughed out of the trachea

David V. Pecora, M.D., Ray Brook Tuberculosis Hospital, Ray Brook, N. Y.; *The New England Journal of Medicine*, September 26, 1963.

into the pharynx. This theory is partially substantiated by the fact that cultures obtained later at pulmonary resection were negative in the one patient with noninfectious pulmonary tuberculosis whose transtracheal culture yielded mixed organisms. Furthermore, past experience indicates that patients with pulmonary tuberculosis and other chronic pulmonary affections almost invariably have sterile lower respiratory tracts at thoracotomy.

The one patient with chronic lung abscess yielded a nonhemolytic streptococcus by transtracheal aspiration on two occasions. The same organism was cultured from the lung when the lesion was excised later. Bronchoscopic culture yielded a mixture of organisms. One patient with bronchogenic carcinoma yielded negative cultures by the transtracheal method and from pulmonary tissue at the time of later thoracotomy. Bronchoscopic cultures were productive of a mixture of organisms.

Transtracheal Method Safe

Transtracheal aspiration is a safe procedure. Approximately 400 have been performed at Ray Brook without a serious complication. Minor complications have consisted of mild subcutaneous emphysema, hematoma, and, in two cases, infection of the needle tract by tubercle bacilli. The latter occurred in patients who harbored viable organisms resistant to commonly employed drugs. Transtracheal aspiration can be performed by the physician in the patient's room after a little training. False-positive cultures may be obtained if a long vinyl tube is used and the patient is permitted to expel the internal tip from the trachea into the pharynx. False negatives may be obtained if the specimen does not contain mucus.

The bronchoscopic technique has many disadvantages. The procedure must be performed by one expert in handling a bronchoscope. It is uncomfortable and cannot be prescribed lightly, especially on repeated occasions. Contamination by oropharyngeal secretions is not eliminated since the tip of the bronchoscope may carry them to the bronchial mucosa. Some agents used for topical anaesthesia are bactericidal, which may reduce the number of positive cultures. The opportunity of obtaining both false positives and false negatives appears to be greater by the bronchoscopic than by the transtracheal method.

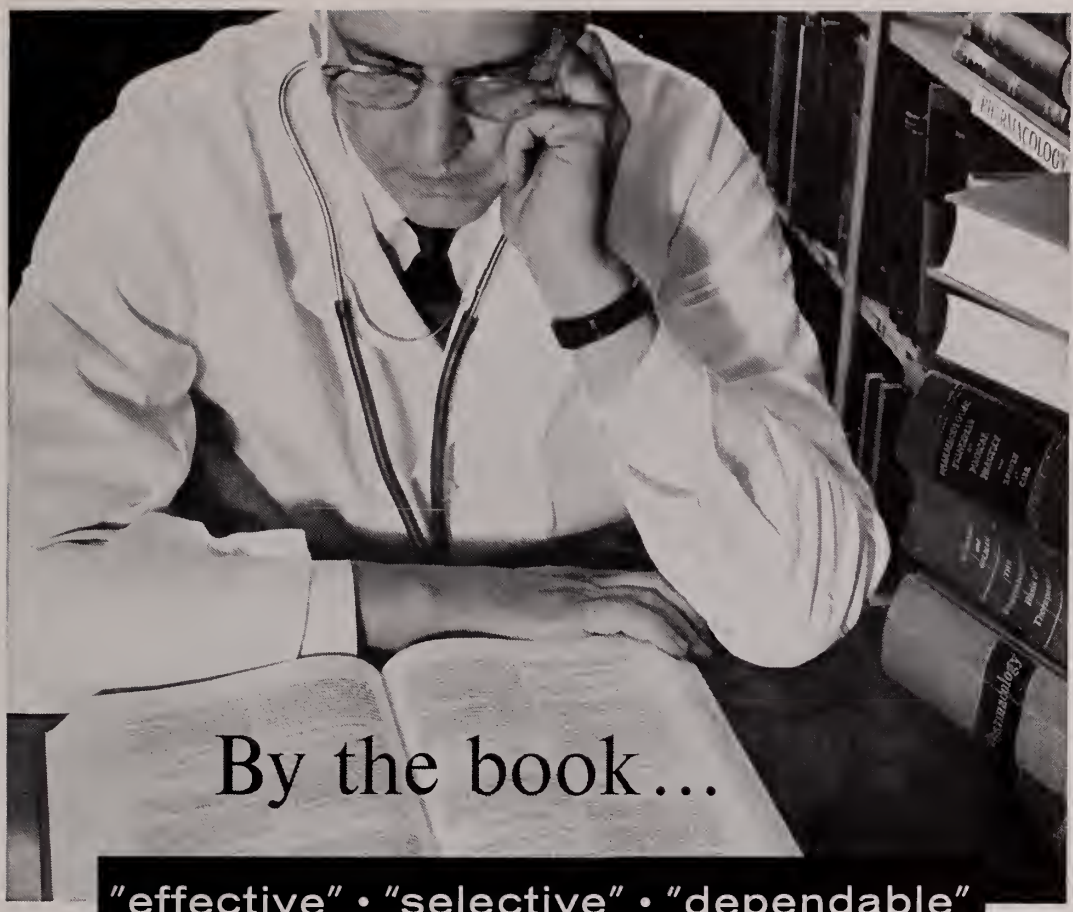
Good Technique

Thus, the transtracheal method of culturing the lower respiratory tract would seem to be the best technique short of open thoracotomy.

Preliminary results of the transtracheal method, confirmed by cultures obtained at open thoracotomy, indicate that patients with chronic cough productive of purulent sputum, who have reddened bronchial mucosa, are heavy smokers, and who may have laboratory evidence of obstructive ventilatory disease, rarely harbor viable aerobic bacteria in the lower respiratory tract. When pyogenic organisms do invade the lower respiratory tract they appear to do so in pure culture and for relatively short periods.

Perhaps the rarity of such chronic infections can be attributed to the widespread use of antibiotics. If this is so, infections of the lower respiratory tract respond readily to small amounts of such drugs, for many of our patients who yield negative cultures by the transtracheal method have received short courses of treatment prior to admission. On the other hand, many patients with no demonstrable infection give no history of drug therapy. It appears more likely that the respiratory tract is able to sterilize itself rapidly. Since they are based upon evidence obtained by examination of expectorated sputum, many of the published data on the occurrence of infection of the lower respiratory tract are useless. There is much evidence that respiratory irritants such as cigarette smoke can cause, or at least intensify, "chronic bronchitis."

New Jersey Tuberculosis and Health Association
15 East Kinney Street, Newark 2, New Jersey



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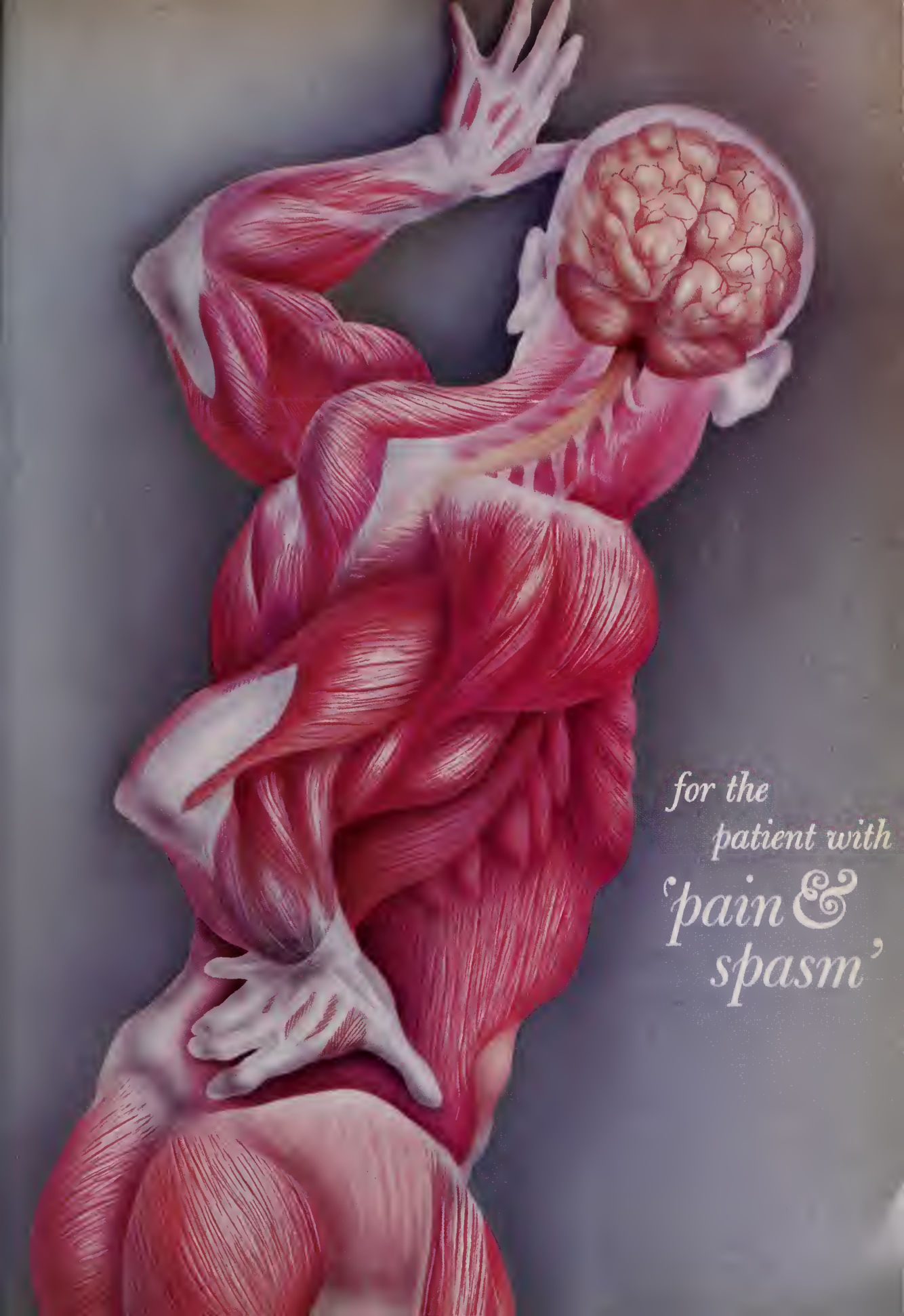
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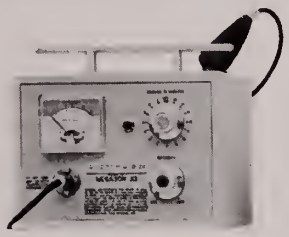
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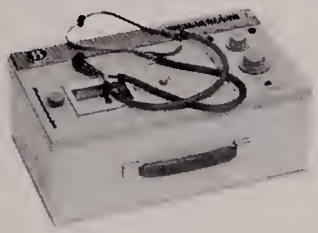
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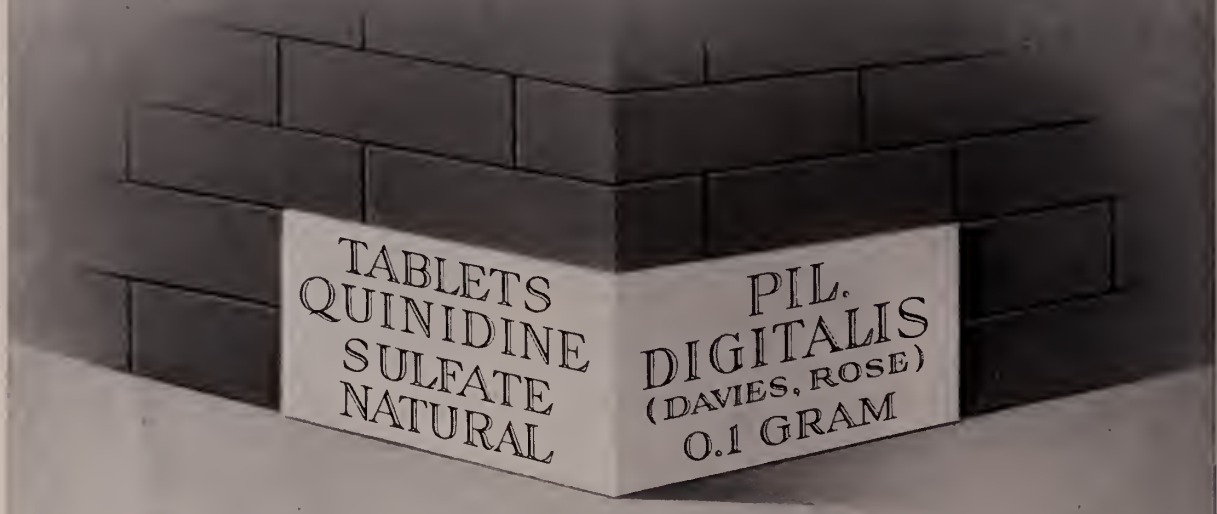
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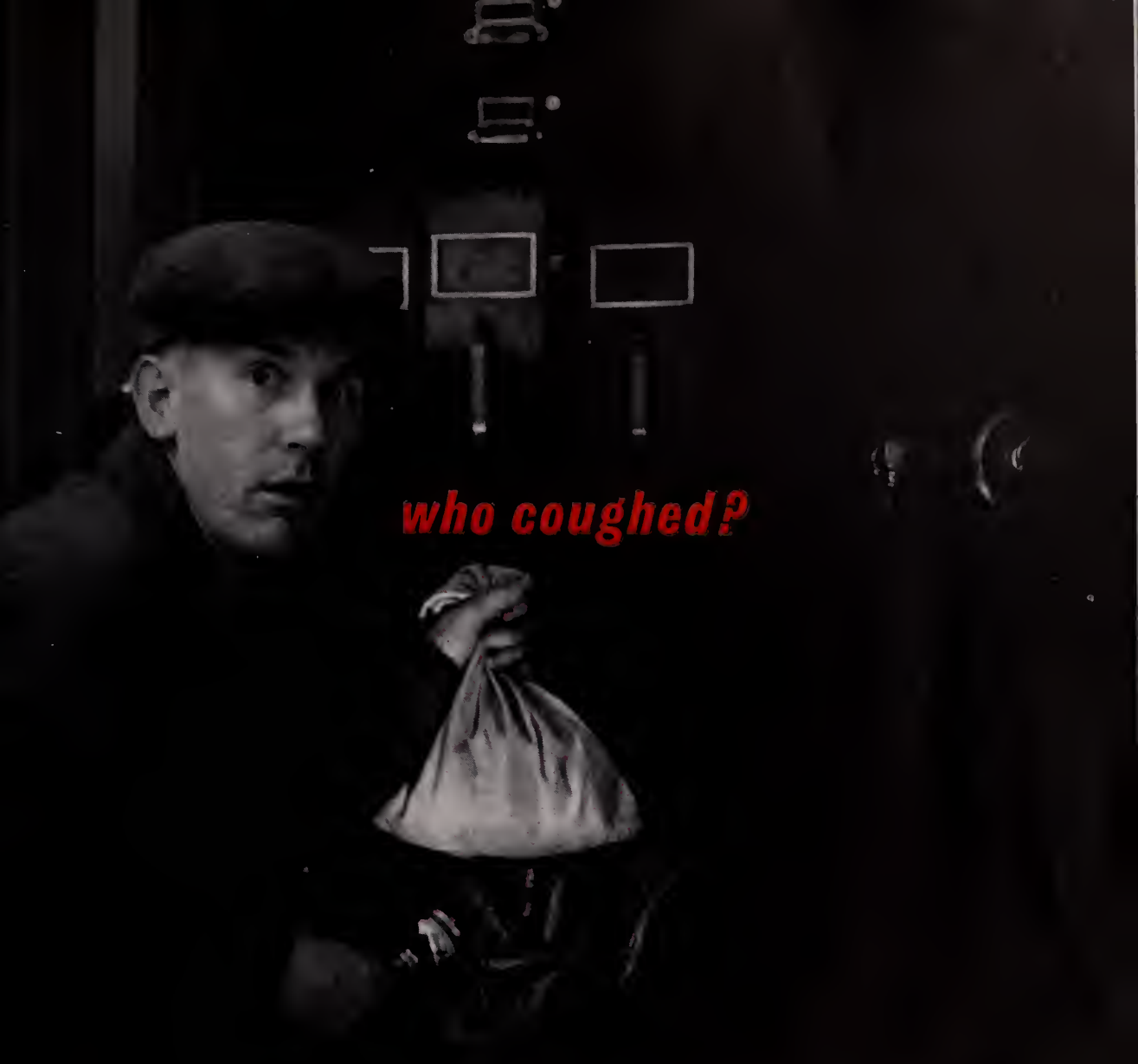
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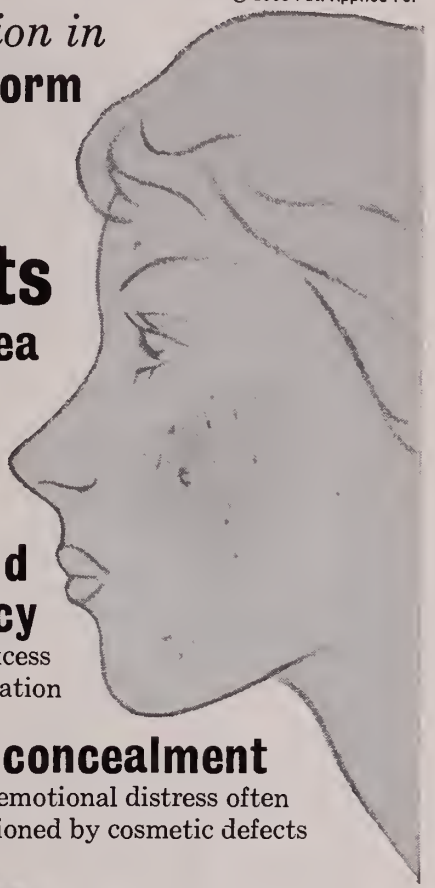
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1. Berger, R. A.: Clinical Medicine, Sept. 1961.

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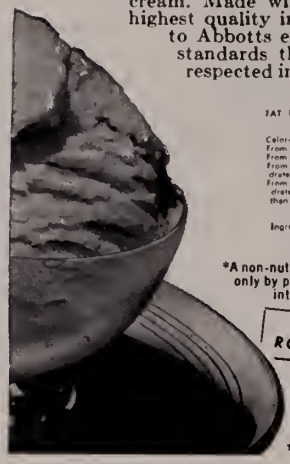
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Schneer, H. I., ed. The asthmatic child; psychosomatic approach to treatment. New York. Hoeber, 1963.

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Shands, A. R. and R. B. Raney. Handbook of orthopedic surgery. 6th ed. St. Louis, Mosby, 1963 *and* U. S. National Library of Medicine. Washington, G.P.O.. 1961. (PHS Publ. No. 871.)



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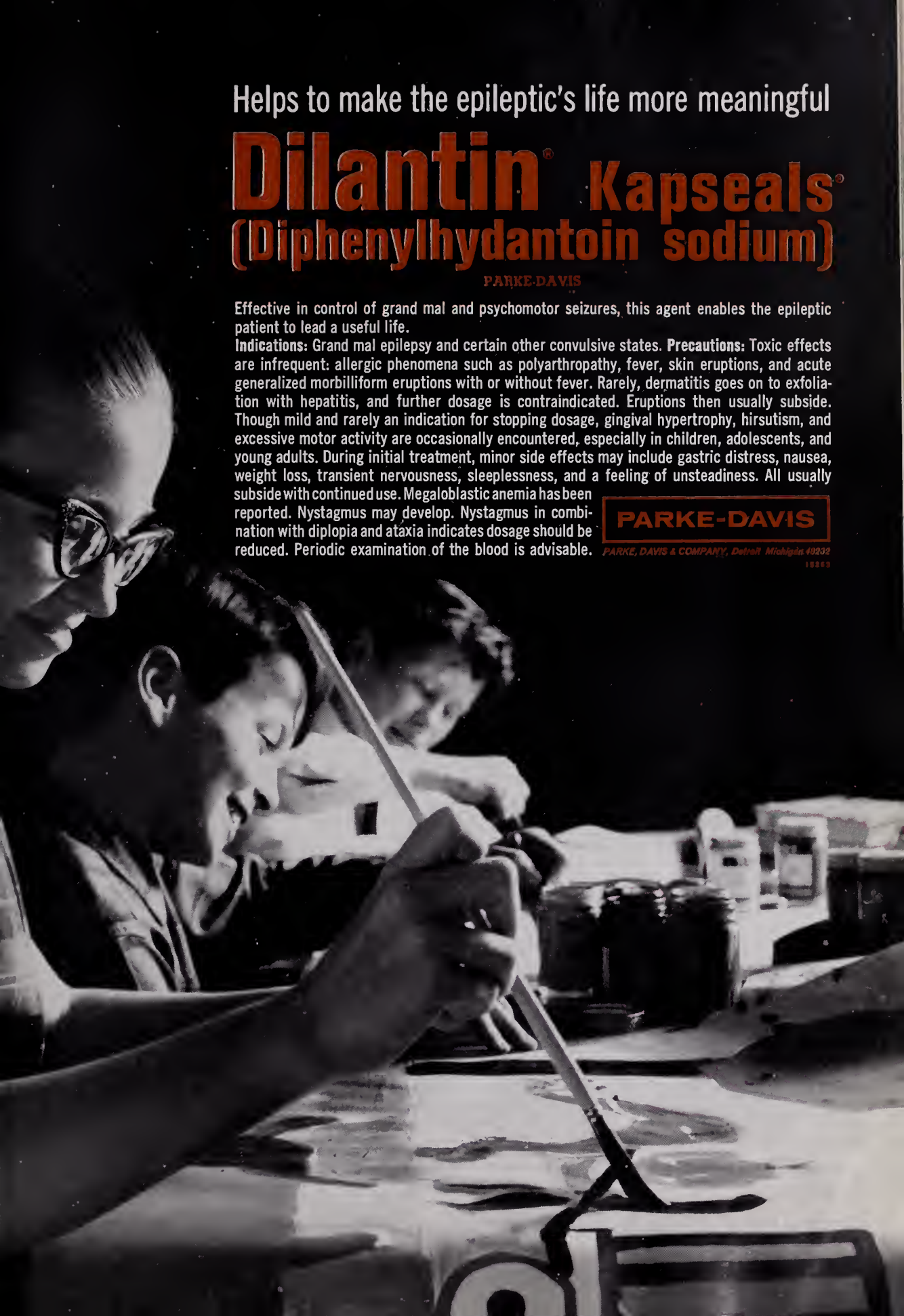
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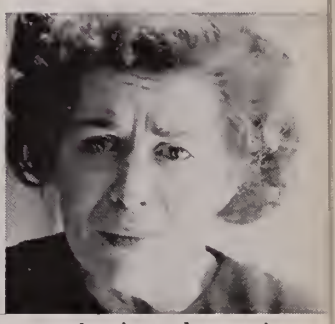
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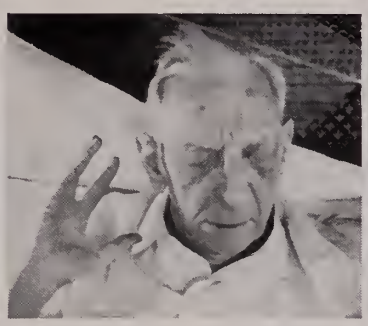
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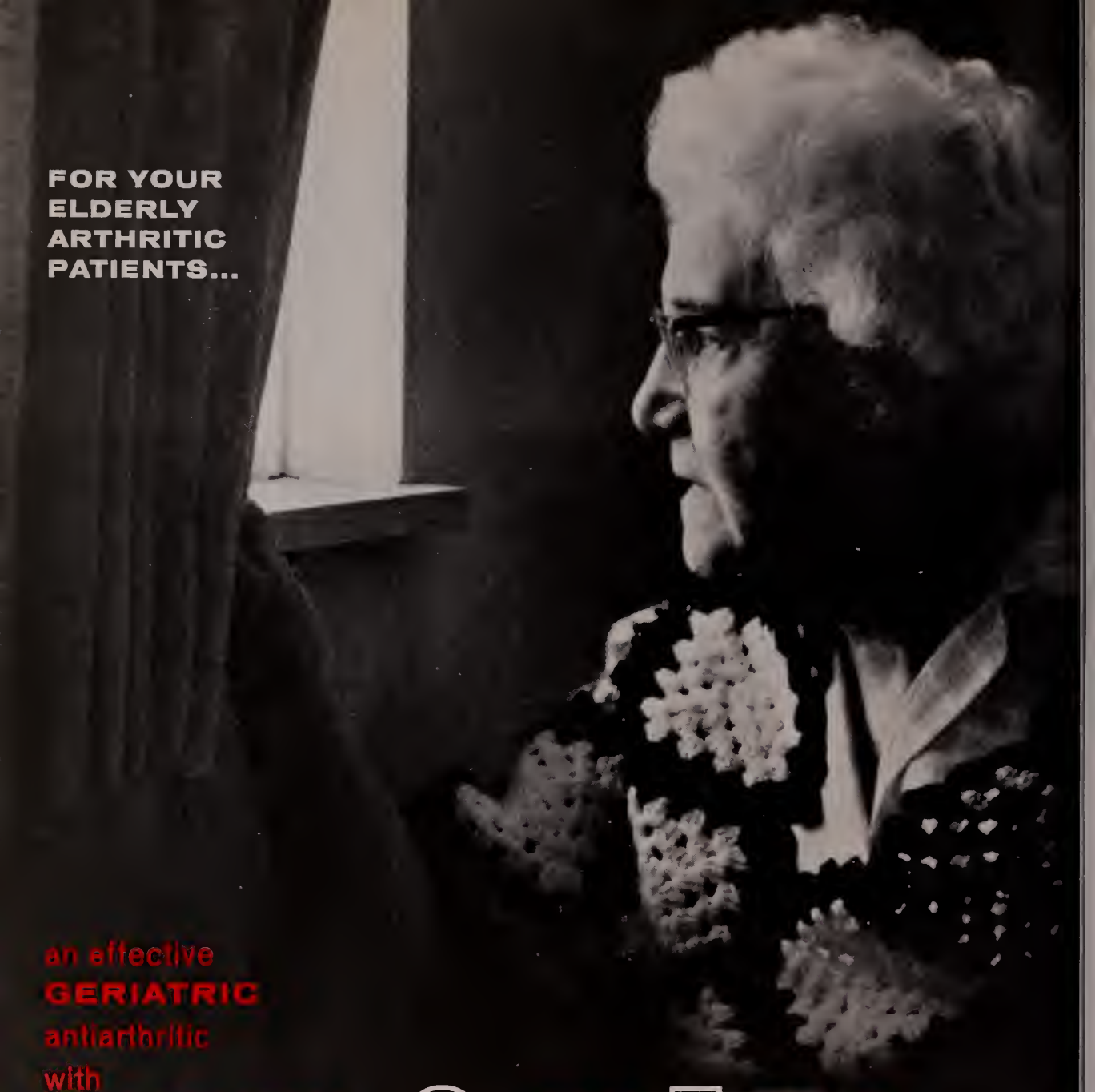
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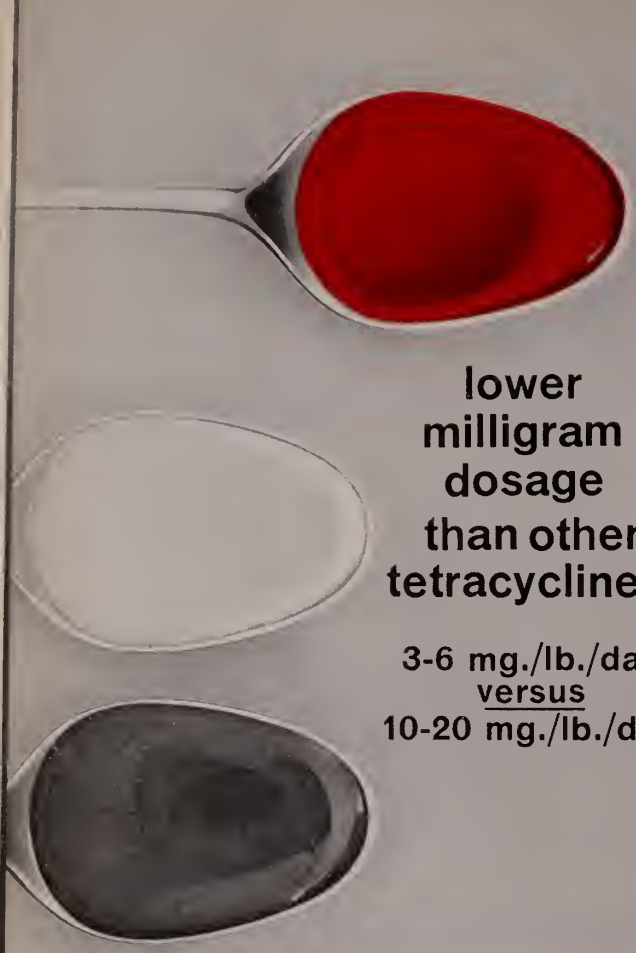
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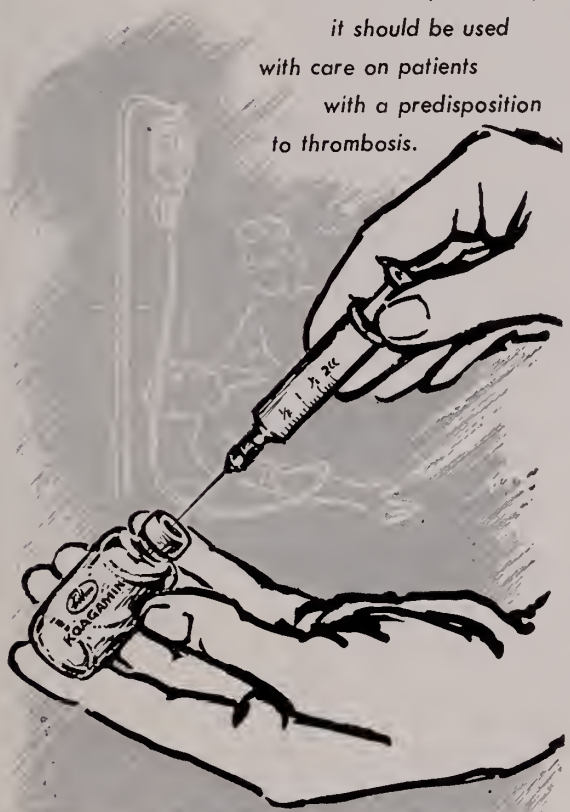
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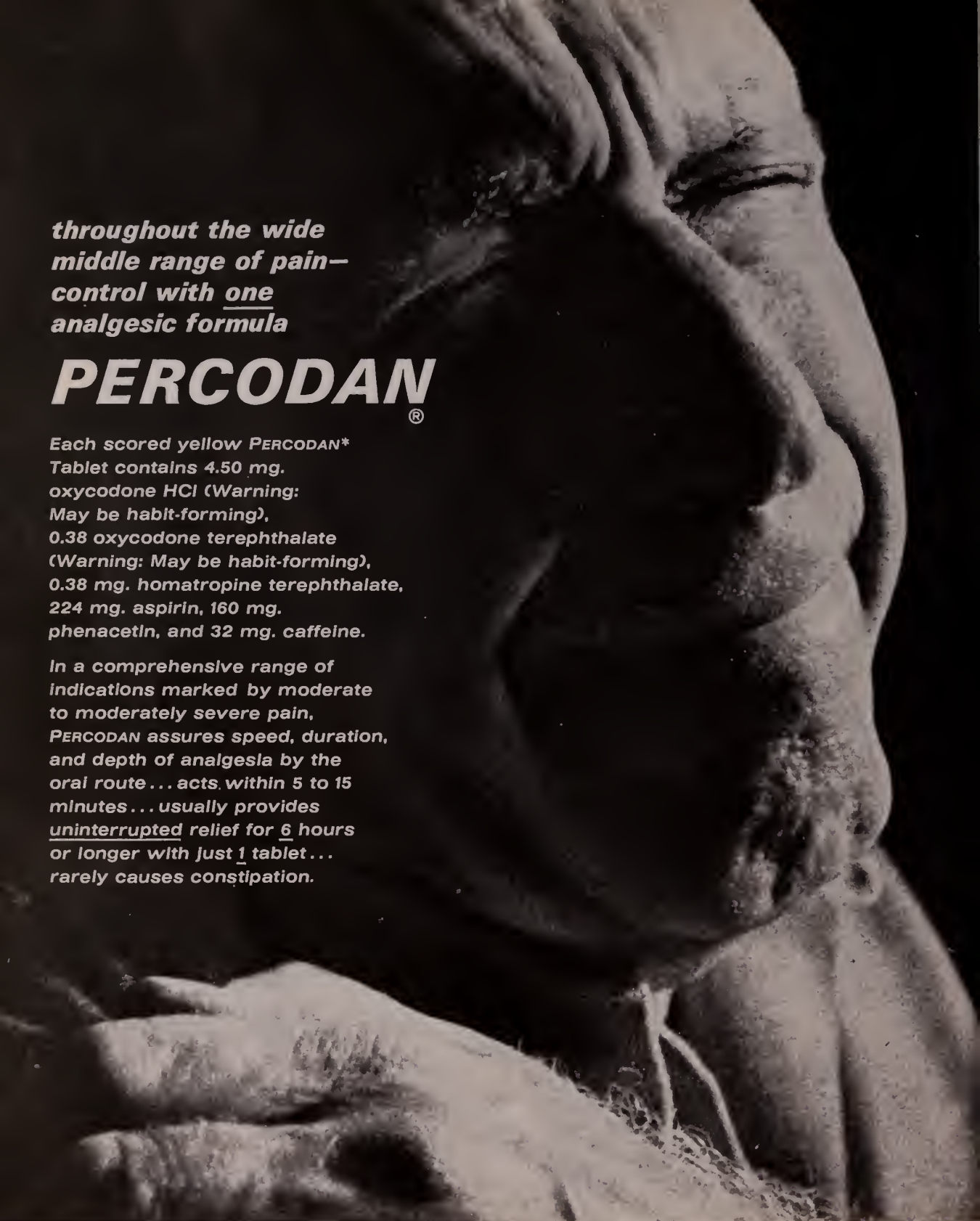
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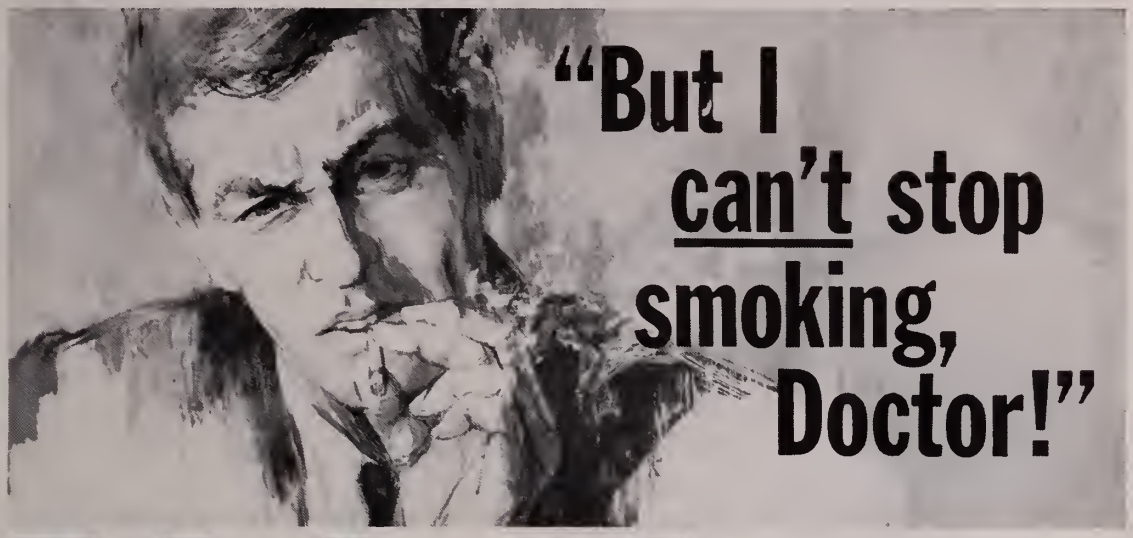
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[1] Simon, F. & Bernstein A.: "The Treatment of Obesity in Patients with Cardiovascular Disease," Angiology, *12*:32-37, Jan. 1961.
[2] Plotz, M.: Modern Management of Obesity, J.A.M.A. *170*:1513-1515 (July 25) 1959.
[3] Bernstein, A. & Simon, F.: "Treatment of Obese Diabetics and Arteriosclerotics," Clin. Med. 907-920, May 1961.

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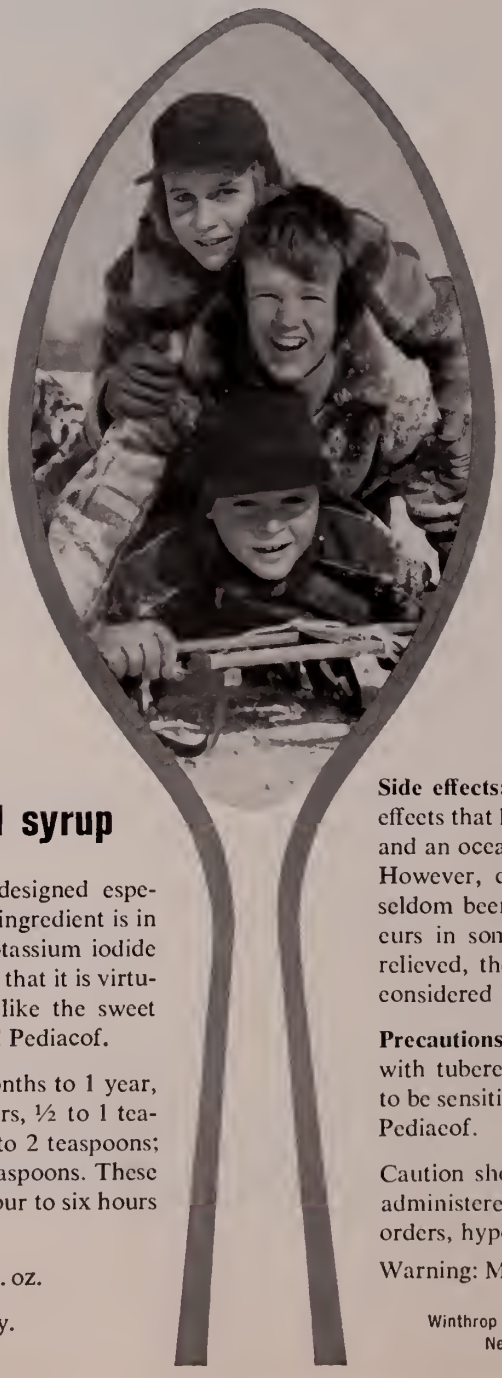
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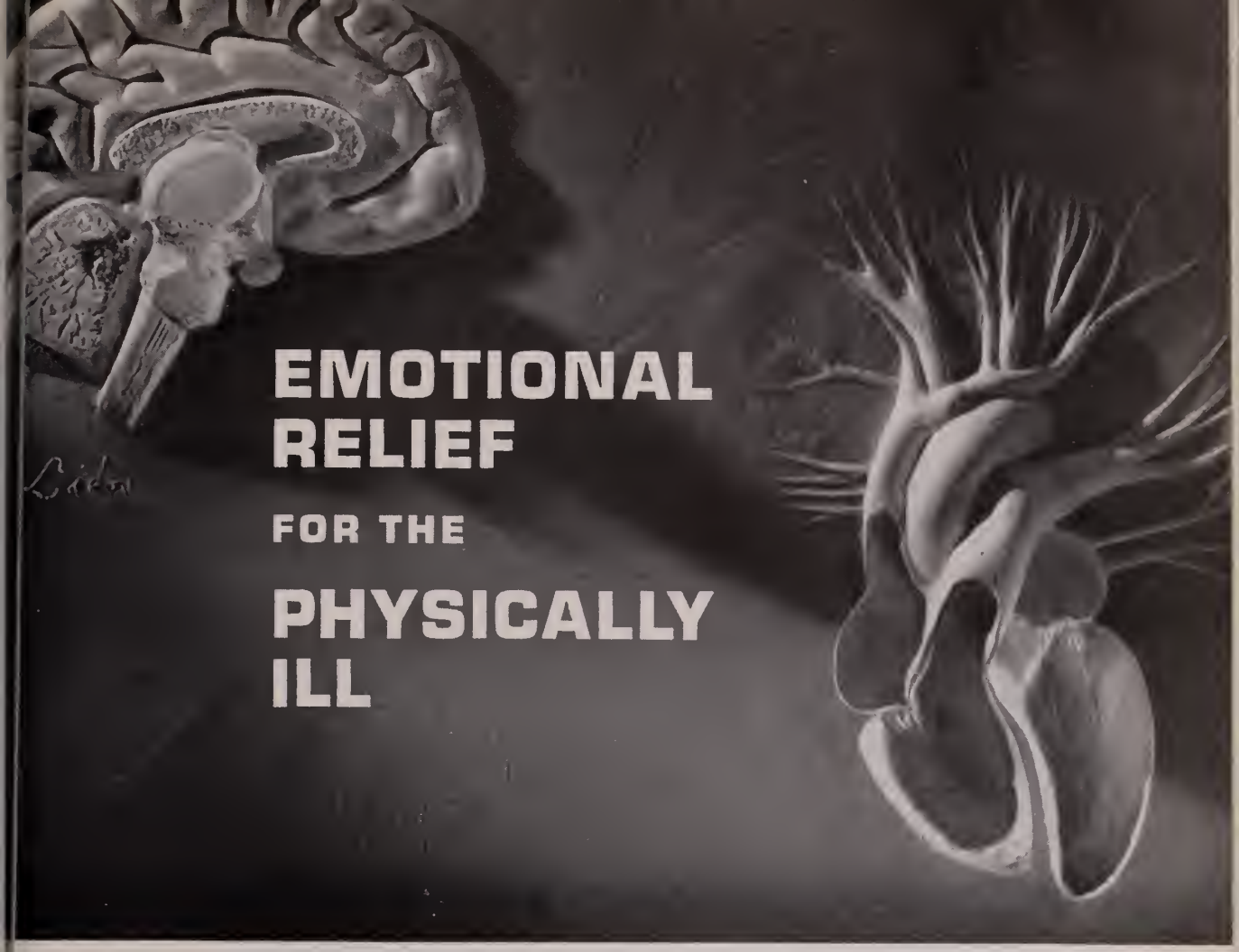
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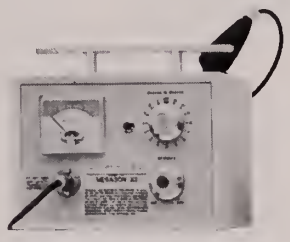
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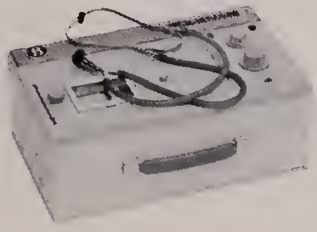
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1. Berger, R. A.: Clinical Medicine, Sept. 1961.

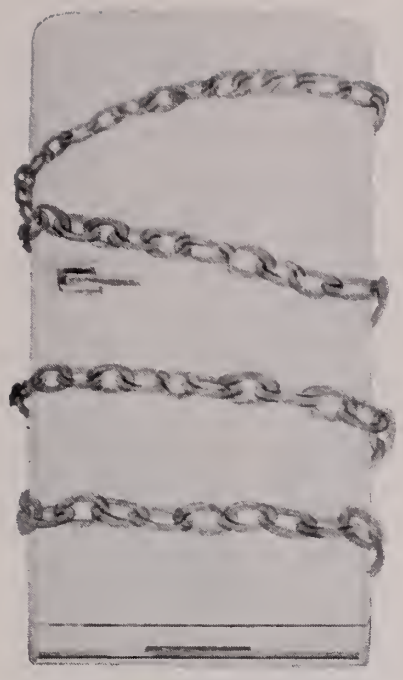
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EDITORIALS

The Visitation of Visitors

Hospital visitors are often laden with candy, flowers, good-will, germs and conversation. This may, as *Hospitals** says, be not what the doctor ordered. Of course, visitors are often good for morale, and cheer up their patients. But the number of hospital visitors each year approximates the total population of the United States —and that's a lot of people to control! If patients suffer when they don't get visitors, they might suffer even more when they do. Visitors not only may introduce infection and clutter hospital lawns with picnic baskets; they may overcrowd wards and rooms, sit on beds, feed candy to diabetics, and raise the blood pressure of nurses and attendants. For fire control reasons, hospitals often have numerous doors and extra stairways, all of which invite visitors the way a flue invites a fire.

And then there is the visitor who depresses the patient with comments on other patients who died of the same ailment; or who in their lugubrious effort at forced optimism make the patient feel he is at death's door.

Harried hospital administrators will probably agree that no matter what they do, they're wrong here. Perhaps they liberalize visiting hours, on the theory that if you spread visitors through more hours, you have fewer per hour. The trouble is that this may mean visitors for breakfast and visitors for midnight snacks. If they seek to limit the problem by shrinking the visiting periods, they merely get more visitors per hour, and the cure is worse than the disease. If they limit visiting to two per patient at one time, they either have to control a flood of frustrated relatives waiting in the lobby, or they encourage a violation of the rule. One remembers the cartoon reading: "Visitors should be enjoyed—not endured."

An Insurance Yardstick for the Public

Do you know enough about actuarial statistics to calculate a fair insurance premium? Probably not. And if you don't, the average layman doesn't either. The skilled insurance actuaries apparently do know. At least they manage, by the magic of their formulae, to keep American companies solvent and to keep insurance premiums within reach. But if the public doesn't understand how rates are calculated, they are bound to object to the increase of rates or the reduction of benefits.

In a free society, the survival of any institution rests upon its ability to satisfy the people it serves. When it fails to satisfy these wants, it gives way to something else. In the case of voluntary health insurance, that something will be compulsory government insurance. The American people know medicine's achievements: they want the benefits. Their desires, by virtue of advances in education and standard of living, have been transformed into a demand. The demand must be met.

Modern medicine is costly by yesterday's standards. The average man cannot pay the bill out of pocket. We have become a nation of the middle class, accustomed to funding every major expenditure through installment plans.

In the light of this, there must be an effective financing device for enabling the average man to avail himself of the medical care his family wants and needs. So far, we have relied, in characteristic American fashion, on voluntary processes. We have looked to the nation's insurance carriers, its Blue Cross-Blue Shield plans and other private groups, to do the job. It is now charged that the voluntary processes are inadequate and must be supplemented by government intervention. Supplementation, in this context, means ultimate substitution.

Medicine and insurance, notwithstanding the preference of both to the contrary, influence

*From the September 16, 1963 issue of *Hospitals*, the Journal of the American Hospital Association.

one another. The kind and amount of the patient's insurance may determine whether he goes to the doctor at all. It may determine his choice of the doctor. Medical practice determines the kind, amount, and cost of insurance coverage written. Health insurance does not manufacture dollars. It distributes them.

Medicine and insurance share a common concern over the rising cost of medical care. Constructive consideration of the problem has been obscured by rate increase hearings, which brought forth loud and widely publicized outcries of abuse, mis-management and inefficiency. Accompanying these charges were demands for vigorous policing of hospital care.

We must give the public a better understanding of the whys and wherefores of medical costs. In most things, the average man has some basis for comparison. He knows what he will have to pay for the things he wants. He can choose the expenditure that will bring him the most gratification, and can bargain with those who purvey it. None of this is true of medical care. Few people know what charges to expect. The patient cannot choose between medical care and something else. He cannot bargain. The insurance buying public is without satisfactory guides for determining the kind and amount of protection it needs, for judging the equity of either medical fees or insurance premiums.

When it comes to publicity, virtue runs a poor second to vice. So the evils and defects of insurance are well publicized. To get the other side of the picture before the public, a way must be found to instruct the layman in the ways in which rates are calculated and to show that insurance just doesn't manufacture new dollars. And it won't hurt some of us to refresh our understanding in this area, either.

Selecting the New Drug

"The desire to take medicine is one feature which distinguishes man from fellow creatures".* The pharmaceutical industry has an oddity peculiary to this one enterprise. The person who selects out of the competing products is *not* the person who pays for the drug. Thus the efforts of the advertiser are focussed at the doctor and not (as in automobile or cigarette advertising) at the purchaser or consumer. "The fruits of the labor of thousands of scientists, the mountains of data amassed by investigators, the millions of words spawned by copywriters, must all be beamed to a single spot: the brain of the individual physician who decides whether to give the particular drug to the particular patient. Experts advise, salesmen cajole, patients may plead. But the physician decides."†

New pharmaceuticals (or new forms of old ones) come out at an average rate of one a day, so that it is impossible to keep up with the flow. Dowling† computes that about half of all doctors learn of a drug that they first prescribe from a detail man; and 20 per cent learn first from mail advertising. Thus, only a minority (surely less than 30 per cent) learn of a new drug through essentially professional channels —lectures, society meetings, or the experiences of other physicians.

If better known drugs don't work, it is easier to see why the practitioner will turn to a new one. While Osler praised "masterly inactivity," this is not part of the American tradition. We are assertive men. To sit and wait for laboratory or x-ray results—to see the patient's symptoms wax with no offer to help—is repugnant to most of us. A doctor who depends on bromides to treat epilepsy would be considered behind the times, and most of us—however nostalgic we may get about the good old days—don't want to be prescribing Fowler's solution for chorea just because our grandfathers did.

What the doctor needs now is not new information about new drugs; rather he needs "to cultivate his analytical ability and improve his critical judgment" in this area.††

*Osler, Williams: *Aequinimitas* (Ed. 3.) Philadelphia, 1951, Blakiston. Page 125

†Dowling, Harry F., Journal of The American Medical Association, 185:256 (July 27, 1963)

††Report of Professional Education Committee, American Heart Association, 1961. Page 10

ORIGINAL ARTICLES

"The neurotic deserves the best in you"—agrees Dr. Sussman in this unpretentious but effective plea for an interest in the total patient.

About Neurotics

Irvin Sussman, M.D./Bridgeton

"Do you in your heart think that a neurotic is just a good-for-nothing seeking a free ride? In your opinion, is a neurotic a sniveler who ought to be tossed into the stream of life and be allowed to sink or swim? If the answer is yes, you had better refer out all your neurotics".[1]

"So that leaves the 30 million neurotics just where they belong—the property and problem of their favorite physician whether he be the old crock on whom they have leaned for 15 years, the surgeon, or the gynecologist. Not a single licensed physician can exempt himself from a share of this therapeutic responsibility. I submit for your consideration the proposition that we have with us a specialty of economic untouchables as far as the great mass of consumers of ambulatory psychiatric care is concerned."[2]

These provocative statements become even more important in view of the data suggesting that the majority of all patients presenting to the office of a medical practitioner have illness of purely psychogenic origin or somatic illness with psychogenic overtones.[3]

Psychosomatic illness may be likened to a multiple tentacled octopus with an emotional center extending somaticized fingers into almost every area of the body.

The emotional stimulus may activate autonomic pathways along any of several routes either singly or in multiples. Indeed, in the highly unstable patient we may find ourselves extinguishing a somatic brush fire in one area only to have the emotogenic torch recede slightly and ignite a new pathway with the production of another "somatic" symptom. Gas and belching may be controlled only to be confronted on the next visit with dysuria, tachycardia, dizziness, and so on. Until we direct our attention towards the underlying emotional fire. the smoldering embers may continue to erupt at the time of each emotional upheaval.

The neurotic may wear many different faces. The following capsulized case histories are illustrative:

Hypertension With Genito-Urinary Symptoms

An attractive middle-aged woman was referred by a surgical specialist for treatment of her hypertension. Frequent catheterizations had been required for urinary retention attributed to "bladder trouble". Other symptoms included constipation, severe headaches, premenstrual symptoms, and dysuria. She said she was "very nervous". Blood pressure of 200/110 was the only significant finding on initial examination. Because of her almost too emphatic denial of any possible emotional problems she was treated on a symptomatic basis until sufficient rapport had been established to initiate more detailed interviews.

Her childhood had been "very strict". She was very close to a very religious father, and when he died "the bottom fell out". "He would turn over in his grave if he knew I wasn't going to church any more". Shortly after her father's death she had a hysterectomy and "I've never been right since". Subsequent to her father's death she married a man twenty years her senior when she was thirty-five. Most of her present genito-urinary symptoms began about two years ago. At this time, her husband had become ill and she had some problems with her libido. Some mention was made about extramarital affairs. Her symptoms were worse at the time of holidays (anniversary reaction) and at times when she visited her father's grave.

Results: As she ventilated the details of the above with many tears, she rapidly and progressively improved. Blood pressure returned to normal without any specific medications. She required no further catheterizations. Therapy has been discontinued, and she has made a satisfactory adjustment.

Comment: Genito-urinary symptoms and hypertension treated by a gynecologist and cardiologist on a somatic basis produced no significant improvement. A better result was obtained by a comprehensive approach which included consideration of the underlying emotional problem. The patient was able to relate her guilt feelings and abnormal grief reaction to the factors in her background. Very few direct statements were made during the interviews since the patient almost spontaneously developed her own insight.

A Vaginal Problem

A young single female had vaginal discharge and odor of three year's duration. Her symptom complex also included premenstrual symptoms, constipation, dizziness, poor health, and "I am sure something is growing inside of me". Examination and studies were negative. She appeared to be intelligent, sensitive, and shy.

She was born in middle Europe and came to this country early in her teens. Her family was of moderate circumstances, retained their "old country" culture, and lived on a farm. The patient had attained a master's degree and taught in college. Her mother died with cancer of the stomach.

She had an unfortunate romantic affair in which she was eventually rejected. At one time there was some question of pregnancy. She felt restricted in her social contacts because of the lowly position and "old country" characteristics of her family. She had decided to give up her teaching career and to return to the farm because of her "ill health".

Result—The somatization of her problems and the mechanism of their development were explained to her. A negative gastro-intestinal series helped convince her that she did *not* have a cancer of the stomach like her mother. Personality assest activation was stressed. Change in her environment was suggested and accepted. She is now doing well in a new position.

Gas, Belching, and Indigestion

A 40-year-old man had been treated intermittently for years for numerous and varied gastrointestinal complaints. Examinations and x-ray studies were consistently negative except for "duodenal irritability". On symptomatic treatment he would be temporarily improved. He was a shy, reticent individual who had difficulty verbalizing.

A marriage of twenty years ended in divorce after a period of separation for eight years. Shortly after the divorce, his symptoms became more severe and more persistent. During the period of separation he lived with a young girl who was many years his junior. He is now in a quandary about acceding to her desires for marriage.

His prior marriage "went on the rocks" because of sexual incompatability. Inadequate marital counselling had resulted in several undesired pregnancies, and an abortion on one occasion had produced strong guilt feelings which persisted. He was able to relate the onset of his wife's "frigidity" to the fear of pregnancy after the abortion occurred.

Result: During his narration of his basic problems, he was able to relate the production of his symptoms to situations that he was unable to "stomach". On his last visit, he stated that he had nothing further on his mind and "had gotten rid of most of my complaints". He has remained relatively asymptomatic and his stomach no longer bothers him. His visits are now primarily for minor "somatic" problems or minor exacerbations of functional symptoms.

Comment: All his gastrointestinal symptoms appeared to be on the basis of a continuous emotional disturbance. After "spilling his guts" he felt much relieved. His guilt over the abortion was a very important factor. With proper marital counselling, any future marriage is more likely to be more stable.

Pseudo-Angina

A young man had been seen in consultation on three occasions during a period of four years: twice for gastrointestinal symptoms and once for cardiac evaluation of chest symptoms. He had been taking tranquilizers and antispasmodics during most of this time. Studies revealed no evidence of organic disease.

His father died of a coronary occlusion shortly before his visit for chest symptoms. His description suggested his father to be a dominant personality who was

never satisfied with the patient's ability or efforts. Resentment, hostility, and ambivalence permeated his comments. Having assumed the responsibility of his father's business, he was constantly plagued by fears of failure in the business which would justify his father's opinions. His brother was a successful executive, and the patient's inflections reflected envy. A sister has been institutionalized for schizophrenia. The patient had no evidence of psychotic tendencies, was happily married, and had three children. Some sexual problems were present but these disappeared early in the treatment.

Results: The patient has adjusted well, has no symptoms, and takes no medication.

Comment: A young man appeared to be heading for trouble with an increase in gastrointestinal and cardiac symptoms. Simple ventilation with a minimum of advice and a maximum of listening permitted this man to resolve his conflicts, fears, and guilt, almost on a "do it yourself" basis.

The Psychiatrist and The G. P.

A question might be raised as to why one whose training has been primarily on the somatic side of medicine might presume to write on this subject. Let it be noted that much of the data presented to the practicing physician has been obscured in such a cloud of psychiatric jargonese that the practicing clinician is frequently left to his own devices in approaching the neurotic patient who is just plain sick. As Alvarez[4] indicates, the practicing physician knows what it is to struggle daily with the problems of differentiating largely functional and largely organic disease and worse yet, identifying organic disease after it has been heavily encrusted with neurosis.

The healing benefits of interpersonal relationships and symbolism have long been utilized by the high priests of yore, witch doctors, faith healers, herb doctors, cultists, quacks, and faddists, with varying degrees of benefit. However, no one has delegated to them the corner on this market. In the last century, Payne[5] stated that the basis of medicine is the desire to help others and whatever is done with this end in mind must be called medicine. It would then behoove us as medical practitioners to face up to our share of this responsibility.

The Doctor As Therapy

Many patients improve despite incorrect diagnosis and incorrect treatment. This would suggest that patients may be more benefited by the dose of the doctor than the doctor's medicine. The following account[5] of Sir James MacKenzie's locum tenens as a young physician is illustrative.

"The astonished locum tenens fresh from his university training and with the memory of the chemist's shop in his mind, beheld a daily procession of men and women few of whom were even slightly unwell coming to demand medicine. Physic, he had been warned by the doctor whose place he was taking, must in this neighborhood satisfy both the eye and the palate. The doctor had a special mixture of his own consisting of burnt sugar and water mixture with a pinch of ginger added. Many of them demanded that MacKenzie should furnish them with bottles of this favourite preparation. It taught him, probably, that a doctor's bottle contains more than drugs and achieves its object by means which are not entirely physical."

In those days it was known as a ginger mixture. Today it has numerous other proprietory names which have made drug stocks so profitable in the past.

The attitudes toward use of the placebo vary widely. "Our aims are to cure if possible, but to relieve in any event. No doctor should feel himself a fraud because he knowingly prescribes a placebo. Nor need he feel distain for his patient because the latter has been helped by it. The patient's discomfort is real."[6]

"The sterile hypo has relieved the minds and feelings of thousands and thousands of patients. Surgery may act as a first-rate placebo under certain conditions. The placebo can under certain circumstances be more powerful than an active drug".[7]

And, may I add, less dangerous.

There has always been a wide swing in the pendulum of enthusiasm for various drugs and procedures. One need only to recall the fleeting popularity of Khellin and testosterone in coronary disease; massive vitamin C doses for rheumatoid arthritis; internal mammary ligation for angina; the vigorous search for eradication of foci of infection and factors responsible for auto intoxication†; duodenal drainage; and

† For a while, in the 1920's, New Jersey achieved fleeting fame as a focus for the removal of foci of infection. In one New Jersey institution, there were many, many removals of half the colons with the hope that this would rid the body of a potent source of poison: the colon bacillus. So popular a procedure has this become, that in our own medical school days (1924-1928), we were identified as coming from the place that converted our colons into semicolons. —*Editor*

high colonic irrigations. Before this it was bloodletting, leeches, and trephining. Yet, despite this, some patients improved and indeed felt better. The medical winds of fashion may blow in different directions but the basic denominator of care remains the same. Psychotherapy has indeed devious methods and the placebo in its many forms has its place.

Sometimes the psychotherapeutic measures may be rather heroic. The multiple lower abdominal postoperative scars on the unstable "neurotic" woman give mute testimony to this, especially when she states how well she did for several months after surgery only to have the same symptoms recur at the time of her next emotional crisis. The following case history is illustrative:

Multiple Hospitalizations

A middle aged woman had symptoms suggestive of angina pectoris. Six months prior to her first visit she had been hospitalized with a diagnosis of coronary occlusion and was still taking anticoagulants. Six operations in the previous six years included cholecystectomy, hysterectomy, laminectomy with spinal fusion, and two laparotomies for "lysis of adhesions." Physical examination revealed a depressed facies, retarded psychomotor activity, and hypertension. Electrocardiogram was normal. Review of the previous tracings failed to produce objective evidence to substantiate a diagnosis of myocardial infarction.

As the youngest of ten children she had been dependent on an overindulgent mother. "I guess you could call me a mommy's girl". She had a "nervous breakdown" at the age of sixteen when her mother died. She had practically no contact with an emotionally rigid father. Two years after her mother's death, she married a man who "reminded me of my mother". When her husband died six years ago, the patient decompensated emotionally with a marked change in behavior. She began to drink, gained weight, and by her own description became quite promiscuous. With history of very little illness prior to her husband's death, in the ensuing years she had twelve hospitalizations including the six operations. A second marriage lasted only a few months. She now had intensive religious preoccupation and withdrawal from most social contacts. She was now living in the home of her married son and has misgivings about her acceptance, future security, and her own dependency on others. She volunteered that she was lonely, frightened, and depressed.

Result—Supportive reassurance, encouragement to be more outgoing with more outside contacts, personality asset activation, and conferences with the family explaining the need for more display of love and affection were some of the measures used. Improvement was quite rapid. The efforts of the family to let the patient know she was needed, loved, and of importance with its attendant restoration of the patient's self-esteem was felt to be one of the major factors in her recovery.

Comment—The progressive downhill course of this patient was altered very little in her exposure to somaticized approaches to diagnosis and treatment. Handling the soma without the psyche was not comprehensive enough to give this patient the help she needed. Surgeons were also participants even though it may be acknowledged that the general medical practitioner or internist carries the major responsibility for sifting the data and properly apportioning the "somatic" and "psychic" components of a patient's symptomatic expression. Body and mind remain indivisible despite the best efforts of specialists to separate them.

The seasoned and experienced surgeon is only too well aware of this kind of postoperative complication. He becomes wary in the presence of an overtly anxious patient. However the "somaticist" can claim some redemption from the observation that a physician receives very little criticism if he misses the boat in diagnosis and treatment of 20 psychophysiologic disorders; but let him miss one organic disease and the long arms of legal, medical, and administrative supervision promptly appear with the pointed finger of indictment. This may apply even where the organic lesion produces relatively little disability as compared with the years of partial or even total functional disability due to a disorder of emotional origin. This attitude has been perpetuated by the public. The layman neither appreciates nor compensates as well the time allotted towards skilled therapy of an emotional illness compared with the time utilized in a relatively simple diagnostic or surgical procedure. More recently, the attitudes appear to be changing with the large influx of articles on psychosomatic medicine.

Problems Of Doctors

Psychosomatic medicine constitutes a significant if not a major part of the clinical aspect of medical practice. How are we physicians responding to it? Do we seek refuge behind the simpler expedient of stating that it is not practical or that there is not enough time? Are we then not candidates for man's incorrigible genius for self-deception? Closer scrutiny of some of the obstacles to the practice of psychosomatic diagnosis and treatment suggests the following problems.

The patient may flatly reject anything suggesting a psychiatric approach. There is an element of stigma based on long standing misconceptions. Some people equate any emotional illness with a psychosis (albeit erroneously), thus making psychiatric referral almost impossible. The physician may have to wear the deceptive cloak of a somatist while applying psychotherapeusis.

Colitis

A young woman had diarrhea for 10 years. Loose watery bowel movements were frequent. Sometimes she had 20 a day. Two sisters also have chronic diarrhea. She had been given a diagnosis of ulcerative colitis. She had been in poor health "all my life"; said she was "very nervous." In her opinion, she had "chronic exhaustion." Because of her illness, she had been unable to work for the past year. She was a thin but attractive, hyperkinetic young lady who attempted to cover her obvious anxiety with forced joviality. Barium enema was negative. Sigmoidoscopic examination revealed spasm and some injection of the mucosa but no ulceration.

The story of her childhood was one of turbulence and emotional trauma. She described her mother as constantly ailing. The patient's social contacts had been limited because she had to stay home to take care of mother. Her strong feelings of resentment had never been openly expressed. Her training in sexual matters was distorted. Her mother described sex as a "necessary evil". She was told that her mother had to get married because she was pregnant. The mother's difficulties in sexual adjustment were transferred to the patient. The mother accused the patient of misbehavior after each date. The patient was told that her birth was another "mistake". She justified her father's tendency to drink too much as "an escape". The patient's major romance was an unfortunate choice. She was first aware of her rejection when she read in the newspaper of her boy friend's engagement to another girl. "Now I don't trust anybody." She withdrew even more and the diarrhea increased.

Result—She flatly refused any efforts at psychiatric referral. She had been previously seen by two psychiatrists. "I would rather die than go again." Treatment was over a period of many months. She obtained a job and moved out of her parent's home. Improvement was gradual but progressive. Transient episodes of diarrhea still occur with emotional crises but are relatively mild and do not disturb her. These recurrences are becoming less frequent and less severe. Her general appearance has greatly improved. Therapy included ventilation in repetitive permissive interviews, provision of informative manuals of the type given to teenagers, explanatory correlation of her symptoms with the autonomics, "prestige suggestion," and environmental and recreational manipulation.

Comment—Although a patient with such deeply rooted psychologic disturbance properly belongs in the province of a trained psychiatrist, her flat rejection of this type of referral motivated the above described efforts to aid her. It is doubtful that the strong feelings of resentment, hostility, insecurity, and dependency coupled with an obsessive, compulsive, perfectionist type of personality are completely resolved by the superficial type of therapy utilized. However she has made a satisfactory adjustment thus far. In the event of decompensation in the future, the suggestion of psychiatric referral is more likely to be accepted.

The Matter Of Attitude

The patient may consider any illness without structural abnormality as a sign of weakness. Unfortunately this may also be fostered by some physicians, consciously or subconsciously. The patient may refuse to recognize psychotherapy as a compensable service. Adequate explanation will substantially reduce the number of patients falling into this category.

The physician may be so wedded to medical orthodoxy that he cannot accept any approach not in accord with his somatically oriented training. The basic field of a specialist may be such as to require him to maintain primarily a somatic approach, especially in some surgical specialties.

The physician may have a feeling of great insecurity in a field where he has had little formal training in the past. Fortunately, graduate courses are now abundantly available to make up for this deficit.

The physician may have so many tensions and conflicts of his own that he becomes uncomfortable in coping with his patient's problems. He may actually fear the possibility of emotional involvement with the patient. Several fine articles[8] are available[9] which should aid in overcoming this problem.

Too much familiarity on a nonprofessional plane with the patient may pose additional difficulty in the objective approach required.

Some patients cover their anxiety with hostility or have objectionable personality stigmata which interfere with the doctor's basic desire to help them.

The fundamental psychiatric diagnosis may be one in which little benefit is to be expected from the superficial type of psychotherapy within the realm of a non-psychiatric practitioner. Diagnosis in this area would include psychoses, phobias and severe depressions.

Psychiatric referral may be made most reluctantly because of prior experiences of inadequate communication from the psychiatrist. More recently these interchanges of communication are becoming more bilateral.

The extent to which any of the above and other considerations interfere with the incorporation of psychosomatic therapy in a physician's practice, of course, varies. Each of us will have to resolve this for ourselves.

Summary

"The neurotic deserves the best in you. Some of the world's best work is done by neurotics. The neurotic has an explicit sensitive conscience which is why he is a neurotic. Be understanding of him. We all have our breaking point. We must all make our compromises and out of compromise have our conflict and guilt. Any one of us may have a neurotic conflict tomorrow".[1]

An exposition of the principles of psychotherapy is beyond the province of this paper. Numerous sources along these lines are now currently available. However, the essence of a psychotherapeutic approach might lie in the final paragraph of a paper[10] written over thirty-five years ago.

"Time, sympathy, and understanding must be lavishly dispensed; the reward is to be found in the personal bond which forms the greatest satisfaction in the practice of medicine. One of the essential qualities of the clinician is interest in humanity for the secret of the care of the patient is in caring for the patient"[10].

And before then:

"A word fitly spoken
"Is like apples of gold in a setting of silver."
—Proverbs 25:11

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Physicians treating pregnant women have a double duty: they must be certain that medication, effective in the mother, will not be toxic to the unborn child.

Iatrogenic Disease In the Newborn*

Eli Scheer, M.D./Teaneck

A familiar example of a physician-induced disability is the problem of retrolental fibroplasia in which an excess of a good thing like oxygen in the small premature may lead to disastrous results. Similarly, we are also familiar with the occasional perforation of the stomach in the newborn associated with the routine aspiration of the stomach in cesarean section babies. In this paper, however, I confine my remarks to the hazards to the newborn from drugs given to the mother during her pregnancy.

It is interesting to note that today's program was suggested to your committee a year ago because we thought we had two unusual case studies to present. Then the international tragedy of thalidomide exploded upon the front pages of our newspapers. Since then our medical journals and all forms of mass communication have been replete with the potential dangers of even common drugs like aspirin to the developing fetus.

I present below two interesting case studies:

Case One

A baby was born to a 24-year old primipara. He was delivered by cesarian section under spinal anesthesia because of an unproductive labor with ruptured membranes in a Class II Cardiac (?). Cry was spontaneous, birth weight was 7 pounds, 1 ounce: no Apgar rating was noted. Routine stomach aspiration was performed, and the neonate was transferred to an isolette in the nursery. This is routine in all cesarian section babies. He seemed to be in good condition until an hour later when the respirations became periodic with alternating episodes of strong cry, rapid shallow breathing, and episodes of apnea, grey cyanosis, and aphonia. Breath sounds were audible on deep inspiration. Heart sounds were of fair quality. Their rate was 130. Also noted was the marked molding of the cranial bones with elongation of the contour of the head. A diagnosis of respiratory distress syndrome, probably of intracranial origin, was entertained, and oxygen at 32 per cent concentration, caffeine sodium benzoate, and intramuscular penicillin was ordered.

When examined the following morning, the baby's condition was extremely poor; exhibiting pale color with circumoral cyanosis, tremors of arms and legs, and extensor rigidity of the extremities with opisthotnos. Also noted at this time was a serosanguinous oozing from the hypodermic puncture site, a trickling of bright red blood from the mouth, and massive ecchymosis of the chest wall where artificial respiratory compression had been applied.

At this time the following antepartum history was obtained:

At about the sixth month of her pregnancy, the mother developed pulmonary emboli secondary to a thrombophlebitis of the legs for which she was hospitalized. She was treated with warfarin sodium USP as an anticoagulant. She was kept on a maintenance dose with a prothrombin time of about 26 to 30 seconds, or about 50 percent of normal up to the time of her admission in labor to the hospital. Then the anticoagulants were withheld until after surgery. I do not know whether Vitamin K was administered prior to the cesarean section.

With this additional history, blood was obtained from the baby for laboratory studies, and large doses of Vitamin K, including its aqueous form, phytonadione, were given intramuscularly. Reports from the laboratory revealed the following:

Prothrombin time: over 100 seconds—control 13 seconds—or less than 1 per cent of normal.

Bleeding time 3 minutes, clotting time over 15 minutes, Hemoglobin 11.5 Gms, Hematocrit 33 per cent; White blood cells 18,000; polymorphonucleus 58 per cent; Immatures 20 per cent; lymphocytes 22 per cent.

The baby's condition deteriorated, and he expired 36 hours after birth. The following quotation is from the necropsy report: "There is considerable intracranial hemorrhage consisting of subdural, subarachnoid, and interventricular bleeding. The bleeding was considered to be spontaneous as no source of bleeding such as tentorial tear or other factor was present. Consequently, death was due to spontaneous intracerebral hemorrhage."

* Read by invitation at the staff meeting, Holy Name Hospital, Teaneck, N. J. on January 11, 1963.

Case Two

A baby was delivered to a 23-year old primipara. Because of placenta previa, delivery was by cesarian section. He breathed spontaneously and reacted promptly. This little boy weighed 6 pounds, 14 ounces at birth. However, he presented a most unusual and spectacular appearance. There were large lobulated semi-cystic masses filling the lateral and mid portions of the neck causing the neck to be extended and the head to be held in the position of opisthotnos. His facies suggested cretenoid stigmata characterized by a flattened bridge of the nose, tilted tip to the nose, and puffiness of the eyelids. However, the tongue was not appreciably enlarged, and there was no definite herniation of the umbilicus. A presumptive diagnosis of congenital goitre with hypothyroidism was made.

A review of this mother's medical history during her pregnancy revealed that she was a chronic asthmatic who had been taking large doses of potassium iodide (approximately one teaspoonful of the syrup three times a day) throughout her pregnancy and for two years prior thereto.

Blood examination of the neonate revealed a serum cholesteral of 72. Protein bound iodine reading could not be obtained because of the abnormally high result —obviously due to the placental transfer of iodine from the mother to the fetus. X-ray of the skeletal system showed that the distal femoral epiphysis was not present; and since this is normally present at 38 weeks gestation, we assumed this supported our impression of hypothyroidism. Accordingly, the baby was put on thyroid grains ¼ daily.

His progress in the hospital was most gratifying. After two weeks the circumference of the neck had diminished from 26 to 21 centimeters, and the distal femoral epiphysis had begun to appear. His subsequent growth and development has been normal. He was kept on thyroid medication for 12 weeks, on a purely empirical basis, and probably could have done well without it. His first tooth appeared at 6 months. He sat up at 7 months, and today is an active, alert, and well oriented 22 month old toddler—who, incidently, has developed asthmatic bronchitis and is *not* being treated with iodides!

Comment

I would like to review briefly some of the drugs which have been found to have an adverse influence on the fetus or newborn infant when given to the mother during her pregnancy[2]:

(1) *Antithyroid medication:* The fetal thyroid begins functioning about the 14th week of gestation. At this time, it becomes subject to the effects of such substances as potassium iodide, radio-active iodine, propylthiouricil, and methimazole—all capable of crossing the placental barrier and causing neonatal goiters.

(2) *Anticoagulants* used to treat thrombophlebitis or embolism may be dangerous to the fetus. Warfarin type drugs should be avoided. Heparin, because of its large molecular size, does not cross the placenta and is the drug of choice.

(3) *Oral Progestins* causing fetal masculinization of female infants. Wilkins[3] cautions against the use of norethindione (17a-ethingl-19-norestonerone).

(4) *Androgenic Hormones:* Grumbach[4] has summarized 14 cases of fetal female masculinization due to testosterone or its analogues even in doses small enough not to cause androgenic manifestations in the mother.

(5) *Estrogens:* Bongiovanni[5] has described virilization of four female infants born to mothers treated with large doses of stilbestrol—postulating a stilbestrol stimulation of the fetal adrenal with increased androgenic output.

(6) *Cancer Chemotherapeutic* agents: Fetal damage (abortions and malformations) has been demonstrated for the antifolic compounds, aminopterin and a-methopterin, when given during the first trimester of pregnancy. Exposure later does not seem to be frought with as much danger.

(7) *Salicylates* are poorly detoxified and consequently inadequately excreted by the newborn. Suspicious hemorrhagic manifestations in the newborn should alert one to the possibility of salicylate therapy in the mother.

(8) *Maternal Intravenous Fluids* are usually safe, but if administered too rapidly, they can alter maternal plasma osmotic pressure and disturb the newborn's plasma homeostasis. A 5 per cent glucose solution given to the mother prior to delivery may cause hyponatremia in the newborn.

(9) *Ammonium Chloride* administered to women at term may reduce the infant's blood pH. Although clinically these babies do not appear to be in any distress, nevertheless this is a potentially dangerous chemical change.

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(10) *Vitamin K and Analogues:* Parenteral administration of large doses of water soluble Vitamin K to mothers in labor increases the incidence of hyperbilirubinemia and kernicterus. This may be due to excessive hemolysis by or a direct hepatotoxic effect of large doses of Vitamin K.

(11) *Hypotensive and Tranquilizing Agents:* Reserpine-like drugs, used to treat hypertension associated with the toxemia of pregnancy, may produce a neonatal syndrome of nasal discharge, costal retractions, lethargy, and anorexia. Some of the tranquilizers have been suspected of having a teratogenetic effect.

(12) *Hemolytic Agents:* A neonate's red blood cells are deficient in glutathione and glucose 6-phosphate dehydrogenase. This predisposes to hemolysis following exposure to the sulfa drugs, naphthaline, primaquin, and nitrofurantoin. Zinkham and Childs[6] reported hemolytic anemia and subsequent hyperbilirubinemia in an infant whose mother had ingested moth balls during her pregnancy.

(13) *Antimicrobial Agents:* Long acting sulfonamides, such as sulfamethoxypyridazine and sulfadimethoxine, cross the placenta, accumulate in the fetus resulting in high blood levels which persist in the newborn and, because of the immaturity of the liver, are poorly detoxified. This in turn may cause hemolysis and the danger of kernicterus. Chloramphenicol administration may produce the "gray syndrome." Streptomycin may affect hearing. Tetracycline may produce transient depression of skeletal growth as well as pigmentation and hypoplasia of deciduous teeth.

Because of the increasing number of highly effective new drugs and because of the poor correlation between animal studies and results observed in human infants, it behooves us to be cautious in prescribing for the pregnant woman. Panelists at a recent meeting of the American Academy of Pediatrics reminded the doctors in the audience that "the administration of drugs is ultimately a medical responsibility and all drugs (except those essential to preserving the mother's life) should be avoided particularly during the first three months of pregnancy".

Primum non nocere

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179 Cedar Lane

Asthma Rehabilitation Program

A rehabilitation program for asthmatics is operating at the Paterson YMCA, with the cooperation of the Barnert Memorial Hospital and the New Jersey Allergy Society.

Breathing exercises and physical conditioning activities are given in a recreational environment. These are adapted to the individuals by an experienced instructor. From the usual exercises, the group progresses to lessons in boxing and Judo. These "combatives" are designed to build self-confidence.

This program has been endorsed by the Passaic County Medical Society and the Asthmatic Children's Foundation. The latter have offered some financial help. It is hoped that doctors in other countries will start such programs. For further details, write to the chairman of the Allergy Society's research committee, Dr. Aaron Weiner of 2232 Radburn Road in Fairlawn, New Jersey.

Properly handled, injuries of cruciate ligaments—an increasingly common type of trauma—need not be permanently disabling.

Management of Cruciate Ligament Injuries

Kirk P. Kalemkeris, M.D./Fort Lee

Injury of the cruciate ligaments of the knee has become more frequent the last few years due to increase in car accidents, athletic participation (particularly basketball, football, and skiing) and the expansion of aviation with the resulting increase in accidents.

These ligaments are called cruciate because they cross each other like the letter X and are identified as anterior and posterior from the position of their attachments to the tibia.

The function of the *anterior* cruciate ligament is to prevent the anterior displacement of the tibia on the femur. This ligament is taut when the knee is in *extension* or in mildly flexed positions[1]. This is why the anterior cruciate ligament is damaged more often than the posterior cruciate ligament which prevents *posterior* displacement of the tibia on the femur and is taut when the knee is completely *flexed*[1].

Rupture of the anterior cruciate ligament is produced by hyper-extension of the knee joint or, indeed, by any force which displaces the tibia forward on the femur. The posterior ligament is frequently injured by direct trauma hitting from before, in the direction of the axis of the thigh. Extreme torsion may rupture both cruciate ligaments. Frequently the rupture is associated with a tear in the internal lateral ligaments or semilunar cartilages, or both. In anterior dislocation of the knee, the anterior (and often the posterior, too) cruciate ligaments are ruptured. Trauma with hyperabduction, adduction, and torsion may rupture all ligaments of the joint and there is sometimes a depressed fracture of the lateral tuberosity of the tibia.[2]

Diagnosis

Patients usually report a severe "wrench" or direct trauma to the region of the knee followed by pain, disability, and a sense of "instability" in the knee. Immediately after the accident, before a marked effusion has developed, the chief objective symptoms are abnormal lateral and anteroposterior movability. These are easily demonstrated. Later, effusion and swelling interfere with extension. This is more important than an impediment to flexion. As to this inhibition of extension, the history must be carefully investigated and the x-rays meticulously studied. The disability, if not due to effusion, may be due to hemorrhage into the sites of the lateral ligaments, to entrapment of an interarticular fibrocartilage, to avulsion of the intercondyloid eminence, or to incarceration of fragments from the torn cruciate ligament[3].

Complete rupture of a cruciate ligament usually leaves extension uninhibited, because the condyles evade by assuming a valgus position. Also, the tibia can often be drawn forward two to three cm. on the femur[4].

The examination for forward displacement of the tibia on the femur (anterior drawer sign)

is made with the patient reclining and relaxed, the knee flexed at an angle of 90°. The examiner seizes the head of the tibia and tries to move it forward and backward. If muscular resistance is felt, another trial is made with the leg dangling or by placing the fist or the forearm beneath the thigh, after which the patient, lying on his back, knee at 160°, tries active extension. In the latter maneuver, it is essential that the examiner be completely passive.

Another cardinal symptom, aside from overextensibility and increased internal rotation (which is much less important than generally believed), is the abnormal looseness of the joint in abduction. This cannot be compensated by muscular action. Also here, a comparison with the uninjured knee is important, because a certain degree of looseness must be regarded as physiologic. Crepitation with pathologic looseness is still more pronounced than with the pathologic drawer.

The so-called "active drawer" and the "snapping knee", developing in the later course, are *not* effects of progressive injury; they are, on the contrary, the expression of improving muscular control[3].

Examination of the joint under anesthesia will often help avoid diagnostic errors.

The severity of injury varies.

Mild Injury to the Cruciate Ligament: In a mild injury there has been some tear in the ligamentous fibers or at one of its attachments, but its strength has not been particularly impaired. Symptoms are: tenderness at the site of the tear, pain on active use of the knee, or forced motion and local swelling at the site of the injury[5].

Significant negative findings are: no instability, no blood in the joint or infiltrated through the tissues, no effusion, no locking, and no pain on normal motion. In this mild injury, prolonged and extensive treatment is not necessary. Fortunately the great majority of injuries to ligaments falls into this group[5].

Moderate Injury to the Cruciate Ligament: This group includes most of the sprains which require extensive treatment. It ranges from those with slight tear to those persons who have only a few intact fibers remaining and whose strength is impaired to a greater or lesser degree. The symptoms are like those of a mild injury, except they are greater in degree, and fluid or blood is present in the joint. There may or may not be locking due to damage to the meniscus[5].

Severe Injury to the Cruciate Ligament: This is characterized by complete loss of function. The tear may be through the ligament, but more frequently it is at one or the other of its attachments. The extremity may be extremely painful. Localized tenderness to pressure is often obtained over the anterior aspect of the joint at a point medial to the patellar tendon. Other symptoms are: swelling around the joint, and fluid or blood in the joint. Complete rupture of the cruciate ligament, usually the anterior cruciate, produces instability which is particularly marked when descending a hill or going down stairs or running and jumping. Occasionally the instability manifests itself during walking, and the man may be forced to walk cautiously with the knee held stiffly. Associated cartilage damage may cause true locking. This is easily distinguished from the pseudolocking, produced by pain and muscle spasm. Loss of tone in the quadriceps muscle is invariably present but is not always so well marked as when a meniscus is torn. Limitation of extension is common.

Rupture of the anterior cruciate ligament is usually associated with injury of the collateral ligaments or other structures of the knee joint.

The most important finding in the determination of severe injury to the ligament is abnormal motion. The cruciate ligaments can be torn with no symptoms of lateral instability and actually with very little reaction about the knee. One may be chagrined to determine after an apparently "moderate" sprain of the knee has recovered that there is complete loss of function of one or the other cruciate ligaments[5].

X-ray Findings

X-ray changes include avulsion fractures of the cortical layers in the region of the femoral and tibial sites of the cruciate ligament attachments, and fractures of the tibia, particularly the intercondyloid eminence. In the old cases there is often evidence of abnormal bone formation in the femoral and tibial fossae of the cruciate ligaments as a result of the looseness and abnormal mobility of the joint due to the primary injury. There may be evidence of an old fracture of the intercondylar eminence. Rational interpretation of the films is possible only after comparison with films of the opposite joint, and, if practicable, views made early in the history of the case[2].

Management

When the symptoms are due to cruciate ligament damage only, treatment will depend on whether the original injury is recent or old. The examiner must determine the degree of loss of function of the involved ligament at the earliest possible moment.

Mild Injury: The basis of treatment of mild injury is, first, protection against further injury; and, second, reduction of local tissue reaction. Immediate application of a pressure bandage with an ice pack will minimize local swelling. Local anesthesia, applied to the injured area, will reduce pain and vessel spasm. Injection of hyaluronidase[5] into the hematoma will speed absorption and reduce swelling and ecchymosis. Protective strapping will permit prompt resumption of activity. The patient may be rapidly rehabilitated without danger.

Moderate Injury: Here emphasis is on protection from further injury. A torn ligament requires at least six weeks for healing, and there should be some period of protection following this. This depends upon the degree of damage. If the greater portion of the ligament is intact, the undamaged part of the ligament may protect the injured portion. Posterior and stirrup long leg splints may be worn for seven to ten days and may then be replaced by a long leg walking cast. Aspiration of the joint should be periodically carried out if the knee capsule remains distended over a long period of time. Corticoid preparation is of value in reducing chronic synovitis[5].

Rehabilitation is important. As immobilization becomes less, a definite program of functional exercises should be developed. Diathermy, a whirlpool, or electric heating pad are useful in improving circulation. Exercises for the quadriceps, ham-strings, and calf are desirable. Meanwhile, complete immobilization is replaced by protective strapping until healing is complete. Ordinarily, complete recovery should be expected with no disability in the joint if the treatment has been adequate. There is no justification for limiting the activity of the patient once healing is complete[5].

Severe Injury: Most authorities say that a complete rupture of a cruciate ligament never heals spontaneously[2], although, following conservative treatment, compensation for this disability may be effected by voluntary contraction of the quadriceps femoris muscle. This occurs particularly in young adults, whose adaptability is great enough to permit the quadriceps femoris to take on what may be called a vicarious or compensatory function and maintain, by its sheer efficiency, the functional stability of the joint. In numerous instances there is no muscular compensation, and there is marked disability due to lack of stability of the knee, recurrent joint effusions, and tendency to subluxation. If cruciate instability is the criterion of operability, the surgeon is justified in giving a light anesthetic to permit a careful test. Strong contraction of the hamstring tendons may result in a negative test for forward displacement of the tibia on the femur. It is, therefore, important that the patient be relaxed at the time the test is made.

O'Donoghue[5] has shown that early surgical repair of the cruciate ligament is quite successful. This has been verified both clinically and on animal. But cruciate ligaments which have been completely severed do not repair unless they are surgically replaced. Surgical repair of the cruciate ligament may result in a normally functioning ligament of good strength provided the repair is performed within ten days[5].

There is, however, one injury where the interruption of the continuity of the cruciate ligaments may be recognized during the acute stage and efficiently repaired; that is in avulsion of the bony attachment of the cruciate ligaments. This injury can be visualized in roentgenograms as fracture of the tibial spine for the anterior ligament and an avulsion fracture of the posterior rim of the tibial condyle for the posterior ligament. Anchorage is obtained by passing a suture through the ligament, and thence through a hole drilled in the condyle of the tibia at the original site of attachment[6].

There are also injuries to the cruciate ligaments, with interruption of the continuity due to fraying and shredding, which are impossible to repair. There is also marked anterior drawer sign, associated with severe lateral and rotary instability of the joint.

Especially in cases with recurrent traumatic episodes in the chronic and grossly disabled cases there are several different possible forms of treatment: (1) permanent brace wearing, (2) arthrodesis, (3) operative reconstruction to establish a new ligament.

Various plastic methods have been suggested. These include looping and fixation, Payr's method of fixation of the anterior to the posterior cruciate ligament, and substitution of the posterior cruciate ligament by an avulsed interarticular fibrocartilage.

One of the widest used technics of operative reconstruction of the anterior cruciate ligament is that of Hey Groves[2]. This operation consists in the transplantation of a pedicled graft of the iliotibial band, threaded through holes drilled in the lateral condyle of the femur and head of the tibia in such a manner as anatomically to replace the anterior cruciate ligament.

Today, the anterior cruciate ligament may be reconstructed by using a strip of the quadriceps tendon, the patella periosteum, and the patellar tendon. Tunnels are reamed through the internal condyle of the tibia and the external condyle of the femur for passage of the new ligament. The new ligament, which is then drawn through the tunnel in the tibia and the femur, is drawn taut with the knee flexed to 150°. The end of the ligament is then attached to the periosteum or to the fascia lata or lateral surface of the thigh[6].

After-Treatment: With the knee held at an angle of 150 degrees, a long night splint is applied and retained for three weeks. Active and passive motion and physical therapy are then instituted. Weight bearing is begun with the knee immobilized in a cage knee brace. A free range of motion is not allowed in the brace until after the lapse of one to two months, depending upon the amount of muscle function which has been restored. Usually, the brace may be discarded two to three months after operation[6]. Following this procedure (Campbell Technic), the following case reported below was operated on three years ago. Results were highly successful for the reconstruction of the anterior cruciate ligament by the use of a strip of the quadriceps tendon, periosteum of the patella and the patellar tendon.

Case Report

A 17 year old man was admitted to the hospital on July 13, 1959 complaining of pain in his left knee and intermittent "locking", He said that he could not extend his left leg without pain.

In May 1959, while playing basketball he twisted his left knee and felt something go out of place laterally. X-rays then were negative, and he had very few symptoms thereafter. He had been asymptomatic until he twisted his left knee for the second time while playing golf on June 21, 1959. Since then he had intermittent locking and pain. The locking seemed to last three or four days before it would unlock and feel better; then, with flexion it would occur again. He had pain anterior medially at that time.

He had a mild effusion on the left knee, and there appeared to be an anterior push-pull with some instability of the lateral collateral ligament with some little tenderness over the anterior portion of the medial meniscus. He could not get complete extension without pain. X-rays showed no bony disturbance.

Pneumo-arthrogram showed that the menisci were satisfactorily outlined with a radiolucent line through the body of the medial meniscus compatible with a tear with no displacement of the fracture fragment at that time. There was a large cyst with an air fliud level within the cyst measuring four centimeters in diameter. In addition there was increased mobility at the knee joints on lateral films with anterior subluxation of the tibia on the femur demonstrated for three quarters of an inch on films made following traction.

The impression was: (1) Torn medial meniscus; (2) Baker's cyst; (3) Subluxation of the tibia on the femur, compatible with tear of anterior cruciate ligament.

Two days after the admission, operation was performed.

Operation:

Under good anesthesia, with the tourniquet applied, a lower portion of a median para-patellar incision was made, exposing the joint. There was a tag of anterior cruciate in the intercondylar notch. The anterior portion of the meniscus looked perfectly normal.

On further manipulation of the joint, pulling the tibia forward under the femur, the loose peripheral portion of the medical meniscus popped forward, its body and posterior portions under the femoral condyle. This was now removed. It was not a real peripheral tear. There was just an eighth of an inch left periphery which was left in place, using the line of cleavage as the line of excision. There was marked instability of the anterior cruciate ligament. The median parapatellar incision was extended up and down routinely to expose more of the knee joint with the patella displaced laterally. There was not sufficient tag proximally to reattach to the distal tag of the anterior cruciate.

A reconstruction was done as follows: The medial section (about a half inch wide) of the quadriceps tendon, periosteum of the patella and the patellar tendon, about four inches long and based distally, was cut off the quadriceps mechanism. A hole was now drilled from the region of the tibial tubercle and the insertion of this new ligament up into the intercondylar notch coming out at the tibial insertion of the anterior cruciate ligament. The new ligament was pulled up through the hole. A hole was now drilled through the lateral condyle of the femur from above down into the intercondylar notch to the site of origin of the anterior cruciate ligament. The new ligament was now pulled up through this hole and sutured with heavy catgut, imbricating on itself to the anterolateral aspect of the femur under the joint pouch. Good stability was obtained, and the limb was supported under the posterior aspect of the thigh and under the heel to keep the tibia dropped back to take tension off of the newly reconstructed ligament. The retinaculum was closed from above down. We were able to close it through the lower end of the patella. There was enough periosteum of the patella left to close to. There was a gap inferiorly, and this was closed by relaxing the medial and lateral retinaculum some distance from the incision, allowing a good closure after the synovium had been closed with a running plain catgut. All of the fascia work was done with #o chromic, fine catgut subcutaneously, wire to the skin.

Long leg cast at 165 degrees was applied with tension released so as to produce laxity of the newly formed ligament.

There was good return of the circulation on release of the tourniquet. The patient returned to the floor in good condition.

Post-Operative Care:
The long leg was retained for six weeks. Active and passive motion and physical therapy were then instituted, and weight bearing was begun in three months.

Conclusions

In management of cruciate ligament injuries, it is of prime importance to determine the degree of loss of function of the involved ligament at the earliest possible moment.

Treatment depends on the degree of the injury:

a. For mild or moderate injury: conservative treatment.

b. For severe injury with complete rupture of the anterior cruciate ligament: surgical procedure is indicated and early repair of the cruciate ligament is quite successful, if it is possible to approximate the ligament.

c. For severe injury with complete rupture of the anterior cruciate ligament, when it is impossible to repair (due to fraying and shredding or avulsion of the ligament): a surgical procedure is indicated to establish a new ligament, especially in the chronic and grossly disabled cases.

It may not always be possible to obtain 100 per cent recovery and a completely normal functioning ligament of normal strength, with reconstruction of the anterior cruciate ligament. But this is due, in part, to the fact that it is virtually impossible for a substitution in the human body to achieve 100 per cent of the standards of its natural predecessor.

Reconstruction of the anterior cruciate ligament has proved successful. A case is presented which was successfully treated by the Campbell Technic.

The author expresses thanks to Dr. Arthur Abelson and Dr. William Bush of Mercy Hospital in Canton, Ohio for their permission to use the case presented in this article.

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Because we seldom think of porphyria, it is an easy diagnosis to miss. Here are some clues.

Acute Intermittent Porphyria*

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Acute intermittent porphyria is a member of the group which includes porphyria cutanea tarda and congenital porphyria. This paper presents two patients with acute intermittent porphyria. The wide range of symptoms in this disease (from blindness to acute abdominal distress) at times defers the correct diagnosis. Utilization of barbiturates in undiscovered porphyria may precipitate or deepen an attack in persons with this potentially fatal disease.

Case One

A 27-year-old man entered St. Michael's Hospital, with abdominal pain and convulsions. He was well until five months earlier when he developed severe intermittent mid-epigastric pain. This was non-radiating and increased in severity up to, and following, admission. Nine days prior to admission he was admitted to another hospital with severe upper abdominal pain. Gastro-intestinal and gall bladder x-rays were done and reported as normal, as was a serum amylase, blood count, and urine studies. The patient was discharged after three days as a "psychophysiological gastrointestinal reaction" and treated with a proprietary tranquilizer. One day before admission he developed a shaking clonic contraction alternating from the left to the right side, with neck extended and eyes deviated to the right. History revealed that he had been involved in an automobile accident ten years ago and had suffered from insomnia since then. He consumed excessive amounts of alcohol, barbiturates, and sedatives in an effort to counteract insomnia. This patient is a product of a normal pregnancy and one of fraternal twins. A maternal uncle is supposed to be schizophrenic and a paternal uncle died from polycythemia. An aunt also has polycythemia.

Examination revealed a normally developed, well nourished man, complaining of blurred vision and severe abdominal pain. His temperature was 101, pulse 110 and regular. Blood pressure was 140/110. The pupils were dilated, and the gaze fixed to the right and downward. Fundoscopic examination revealed marked narrowing of the arterioles with spasm and tortuorsity. No papilledema, hemorrhages, or exudates were seen. The lungs were clear, and the heart had a regular sinus rhythm with a rate of 110. The abdomen was soft and no masses or enlarged organs could be palpated. Genitalia and rectal examination were normal.

Neurologic examination showed that the patient was able to distinguish light and darkness. He had tonic deviation of the eyes to the right with nystagmoid motion. Motor examination was normal. Reflexes were normal. On admission, meperidine† was given for pain and amobarbital† for a generalized convulsion. Laboratory work included a serum amylase and a urinalysis for porphyrins. The urine voided the next morning was dark brown. A Watson-Schwartz test was positive for porphobilinogen, porphyrins, and uroporphyrins. Blood count, sedimentation rate, amylase, blood sugar, blood urea nitrogen, calcium, phosphorous, protein bound iodine, catechol amines and urine hematest, VDRL, bilirubin, SGOT, and an alkaline phosphatase were all within normal limits. Urine gave a positive test for protein. Specific gravity was 1.021, and the sediment contained ten white cells and a few granular casts per high power field. The stool for occult blood was negative; SGOT 50 units; BSP demonstrated 26 percent retention 45 minutes; spinal fluid; serum proteins were 106 milligrams per cent. Serology was negative; colloidal gold was normal. Electrophoresis of spinal fluid revealed a small amount of globulin. The porphobilinogen content of the spinal fluid was negative. Quantitative coproporphyrins in the urine amounted to 44 micrograms per 24 hours. This is high, though the range of normal may be anywhere from 4 to 50. However, the urine normally has no uroporphyrins, but in this patient we found 60 micrograms in 24 hours.

The day after admission, he had another generalized convulsion. He remained hypertensive (160/110), irritable, and continued to complain of blurred vision. He was placed on two Grams of Disodium Versenate intravenously for three days while continuing on prochlorperazine (trade named compazine®) until his discharge. After one week, the urine became lighter in color. Blood pressure returned to a previous normal level, and he became alert and his vision normalized. Spinal fluid protein remained elevated at 180 milligrams per cent. Spectroscopic examination of the urine revealed typical porphobilinogen absorption at 560 micra. The patient was discharged greatly improved after two weeks.

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* This work is from St. Michael's Hospital in Newark, where Dr. Sanowski is chief resident in medicine. Dr. Ritota is director of medicine at the Columbus Hospital in Newark and associate in medicine at St. Michael's.

† The authors used the Winthrop brand of meperidine, tradenamed Demerol® and, for amobarbital, the Lilly brand tradenamed Amytal®.

Case Two

A 34-year-old woman came into the hospital with pain over the lumbadorsal area which radiated to her abdomen in a "colicky" fashion. For five years she had had such pains accompanied by fainting spells, nausea, and vomiting. Convulsive episodes accompanied some of the attacks of abdominal pain.

Her mother and brother, though asymptomatic, were found to have quantitative amounts of uroporphyrins. This was discovered after the present study.

She was a well developed, well nourished woman in no acute distress. Pulse, blood pressure, pupils, and fundi were normal. Chest was clear upon auscultation and percussion. The heart was regular at a rate of 80. Abdominal and pelvic examinations were normal as was the neurologic examination.

Laboratory studies included gall bladder and gastrointestinal x-ray series; barium enema; pyelogram and spinal x-rays. All were normal. The blood count, blood glucose, blood urea nitrogen, creatinine and cephalin-flocculation test were all within normal limits. The urine showed a trace of albumin; specific gravity was 1.026 and fourteen white blood cells per high-power field.

Provisional diagnosis was conversion-hysteria. She was treated with tranquillizers. Under this regime, abdominal pain increased and necessitated meperidine† following each administration of phenobarbital. This aroused the suspicion of acute intermittent-porphyria. The coproporphyrin in the urine was 1900 micrograms per 24 hours. Normal is 150 a day. Uroporphyrins: 10,300 micrograms per twenty-four hours. (Normally this should be zero.) Porphobilinogens amounted to 8 micrograms per day; the normal here, too, is zero.

The urine turned burgandy red on standing. Serum phosphorous and thymol turbidity were normal with a BSP of 33 per cent retention. Sedatives were discontinued, and she was started on prednisone‡ in conjunction with B^{12} intramuscularly. The patient improved after two weeks of treatment and was discharged.

Acute intermittent porphyria is distinguished from the other types of porphyria by frequency of gastrointestinal and neurologic symptoms and absence of skin photosensitivity. A patient in the acute stage will excrete in the urine porphobilinogen[1] a colorless porphyrin precurser. When added to Ehrlich's aldehyde reagent, this forms a red compound insoluble in chloroform[2]. Porphobilinogen is not excreted in congenital porphyria and rarely in cutania tarda[3]. The congenital form is inherited as a Mendelian recessive. The acute intermittent type is inherited as an irregular dominant character which is not sex-linked. There is variation in the character, but about 25 per cent of siblings may be expected to have porphobilinogen in the urine[4].

‡ The authors used the Schering brand of prednisone which is tradenamed Meticorten®.

The porphyrias are metal-binding pigments which enter into the formation of respiratory enzymes, hemoglobin, and myoglobin. The basic compound porphyrin is composed of four pyrrole rings joined by carbon atoms and differ among themselves in their isometric configuration and in their side chains[5].

The important porphyrins in disease are coprophrin I, III, and uroporphyrin I.

Porphyria erythropoietria (congenital or photosensitive porphyria) is rare. It is characterized by overproduction of uroporphyrin I and coproporphrin I in the blood forming organs. Uroporphyrins accumulate in subcutaneous tissues and give rise to photosensitivity. The urine, teeth, and bones have a reddish color; and there may be splenomegaly and hemolytic anemia[6]. The urine contains increased amounts of coproporphyrin but no porphobilinogen.

Porphyria cutanea tarda has its onset in the fourth to sixth decade, and is probably the result of a metabolic defect in the liver. It is seen as a complication of alcoholic cirrhosis. Skin reactions (as a result of photosensitivity) are present and range from increased pigmentation to a chronic exzematous dermatitis with or without the formation of bullae. A particular bullous form, hydrea aestivole[7], also occurs. Both uroporphyrins and coproporphyrins are present in increased amounts; but no porphobilinogen is present.

Acute intermittent porphyria is the most common form. Age of onset is usually in the third and fourth decade. Females predominate. It is questionable whether the sex incidence is genetically determined or whether precipitating factors, as pregnancy or barbiturate intoxication[8], predispose to the difference in sex. The condition may be chronic but it is noted for its acute exacerbations and remissions. Attacks may be short, and neurologic symptoms may predominate. The gastrointestinal involvement is manifested by severe "colicky" abdominal pain accompanied by nausea, vomiting, and constipation. The pain may be experienced in any part of the abdomen but is most often in the epigastrium and right iliac fossa and may sug-

gest an acute surgical crisis. The abdomen is usually soft and tender. Rebound tenderness is absent.

The neurologic component is of special interest. Any part of the nervous system may be involved. Symptoms may be referrable to disturbance in the cranial, peripheral, and autonomic nervous systems. Patients may have motor disturbances, such as paralysis or paresis of limb muscles with diminished or absent tendon reflexes accompanied by muscle wasting. Cranial nerve involvement (diplopia, dysphagia, dysarthria, aphonia, and temporary loss of vision) is not unusual. Sensory disturbances, nystagmus, and cerebellar ataxia may confound the clinical picture. Epileptiform seizures have been described in acute episodes as were seen in our case one. Patients with acute porphyria are frequently diagnosed as psychophysiologic, hysterical, or psychotic reactions. They are frequently "sedated" with phenobarbital, thus further complicating the management problem. Cardiovascular findings may include hypertension, tachycardia, and non-specific ST segment changes on electrocardiogram.

Diagnosis

The diagnosis rests on the discovery of porphobilinogen and uroporphyrins in the urine. Spectroscopic absorption at 560 micra confirms the presence of prophyrins. The precurser of porphobilinogen (delta-amino levulenic acid) is found in the urine in the symptomatic and quiescent stage and may aid in diagnosis[9]. Paper chromatography[10] is of help in discovering the presence of small amounts of porphobilinogen[11] excreted in a twenty-four hour urine specimen of a patient or relative of a patient with suspected porphyria[12].

Comment

The possible familial aspects of the first case are presently under study. At the present time there is no specific treatment for acute intermittent porphyria, prevention of the attacks, and diagnosis of this condition is especially important. In the acute attacks morphine or meperidine† may be used to relieve pain. Paraldehyde or chloral hydrate are safe hypnotics. If the patient has signs of diaphragmatic paralysis, an artificial respirator should be swiftly available.

In our two cases, prednisone‡ and calcium disodium versenate were used. Treatment is difficult to assess because of spontaneous remissions. The underlying pathology has not been clarified, but demyelination of peripheral nerves and white matter[13] has been seen at post mortem in patients with acute intermittent porphyria. This may account for both gastrointestinal and neurologic symptoms.

Summary

Two cases of acute intermittent porphyria are presented with a brief biochemical review. The importance of a correct early diagnosis with the avoidance of unnecessary surgery and the erroneous affixing to these patients of a psychophysiological reaction is emphasized.

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A combination of glyceryl guaiacolate and oxtriphylline was found moderately helpful in the management of patients with chronic pulmonary and bronchial disorders.

Treatment Of Bronchial And Pulmonary Parenchymal Disorders

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Several relatively recent publications[1], [2] indicate that complicated chronic diseases involving the bronchi and pulmonary parenchyma occur in young adults almost as frequently as in older ones. Generally, the disease process is gradual, may exist for considerable time in a relatively unchanged state, and may not produce symptoms of respiratory insufficiency until middle age. Aging may be a contributing factor, but the aging process is not the basic underlying cause. Chronic progressive emphysema, for example, is seldom seen in patients over the age of 65, because those who have this disease usually do not survive long enough to reach old age[1]. Most often, the onset of symptoms associated with pulmonary insufficiency occurs after the age of 40, and usually results from repeated bouts of acute respiratory infections[2], [3]. Patients with complicated chronic respiratory disease can seldom expect that their condition can be completely reversed. Nevertheless, careful attention to specific needs, meticulous evaluation of factors involved, and application of principles to correct or relieve the pathogenic mechanisms can provide symptomatic improvement. This is often sufficient to dispel the notion that the condition is hopeless. Numerous therapeutic measures can be used. The basis of such regimes must be a simple, safe, easily administered and, preferably, well-tolerated maintenance medication. Two of the most effective medications include bronchodilators and/or expectorants. Recently, a new preparation was introduced in which the bronchodilator, oxtriphylline[4], [5], [6], [7] and expectorant, glyceryl guaiacolate[8], [9] have been combined*. Because of the reported effectiveness of the individual components, it was decided to use this preparation (under double-blind conditions) in the management of a series of patients who had complicated chronic respiratory disorders, and to compare the results obtained with those resulting from the use of a bronchodilator (oxtriphylline) alone.

Procedure

Twenty-five patients (6 were women) ranging in age from 27 to 80 years (mean age, 62) were included in the double-blind study. They had severe, advanced, complicated disorders involving the bronchi and pulmonary parenchyma. Diagnoses included chronic bronchitis in 12, pulmonary fibrosis in 7, bronchial asthma in 3, allergic bronchitis in one, and senile emphysema in one. All but two were complicated by severe disorders such as emphysema, cor-pulmonale, arteriosclerotic heart disease with chronic failure, and bronchiogenic carcinoma. Fourteen had been receiving the following medicaments: bronchodilators, 2 patients; antibiotics, 6 patients; and digitalis, 6 patients. Seven of the 14 patients were experiencing side effects on previous therapy. All previously prescribed medication was discontinued before the study was initiated.

Each patient received each test agent for four weeks in a double-blind randomized order, with a crossover of medication at the end of the first

*Supplied by Warner-Lambert Research Institute, the research affiliate of Warner-Chilcott Laboratories, Morris Plains, New Jersey.

four weeks, making a total of eight weeks for evaluation. The tablets were coded and the code was not broken until the study was completed. The prescribed dose was one tablet four times daily. Each tablet contained 200 milligrams of oxtriphylline; in addition, the combination tablet contained 100 milligrams of glyceryl guaiacolate.

Before the study was initiated, the following factors were evaluated: physical examination of the chest, cough severity, wheezing severity, frequency of wheezing, amount of expectoration, ease of expectoration, a battery of laboratory evaluations, and two (vital capacity and timed vital capacity) function tests. These criteria were evaluated at two-week intervals.

Results

One patient. a 76-year-old man who had had bronchial asthma and bronchiogenic carcinoma with secondary infection, died during the study. The medication prescribed was in no way implicated. Results, therefore, were based on an evaluation of 24 patients who completed the investigation.

Objective Findings—Favorable increases (not statistically significant) were observed in the vital capacity and timed vital capacity of the patients following treatment with both medications. Additionally, physical examination of the chest (based on percussion, auscultation, and accessory respiratory movements) indicated that improvement had taken place in approximately 71 per cent of the patients. The favorable results produced by both medications, when compared with pre-treatment findings, were not statistically significant. A statistically significant decrease in the average amount of expectoration, as measured daily by the patients, was reported following the 4 week course of treatment with the combined preparation. The superiority of this medication was shown by the fact that the ratio of patients expectorating more than 30 cubic centimeters of sputum prior to treatment was decreased by 33 per cent (83 to 50) ; while following treatment with the bronchodilator alone it was decreased by only 17 per cent (83 to 66).

Subjective Findings—Clinical improvement in the severity of wheezing followed the administration of both agents. Differences between the pre- and post-treatment evaluations for both medications were not statistically significant. In the categories of cough severity and frequency of wheezing, both medications produced statistically significant results. Decreases in the severity or frequency of the specific criteria were noted in approximately 40 per cent of the patients in whom these criteria were initially rated as being moderate or marked. Final tabulations of the data indicated that greater improvement in the ease of expectoration had taken place when the patients were taking the bronchodilator than when they were taking the combined preparation; the rate of improvement was statistically significant.

When all the criteria were evaluated to determine the overall results of therapy, it was found that an equivalent number of patients were rated as having obtained an excellent or good response to treatment with both of the medications.

As recorded at the final visit, side effects occurred in five patients while they were receiving both medications. In no instance was it necessary to discontinue medication, however. Heartburn and nausea were common to all patients reporting side effects, and one additional patient experienced epigastric pain on both preparations. Four of these patients were experiencing side effects from previous therapy at the time of institution of the study; however, fewer side effects were experienced on both of the test-preparations than on previous medication.

The safety of both medications was clearly evident. Laboratory results showed no significant alteration in urinalysis, hemoglobin, leukocyte count, differential leukocyte count, platelets, blood urea nitrogen, and one or more of alkaline phosphatase, serum glutamic-oxalic transaminase, thymol turbidity, or cephalin flocculation tests.

Comment

Collectively, the results obtained in this study demonstrate that clinically significant symptomatic improvement can be achieved with relatively simple maintenance therapy in patients who have complicated chronic pulmonary disorders. In certain specific criteria, such improvement was definitive enough to be statistically significant. The results also indicate, however, that bronchodilators alone (and in combination with expectorants) do *not* consti-

tute "complete" therapy for all patients, even though such medications are considered to be two of the best basic maintenance drugs for the management of patients with chronic pulmonary disorders. This is undoubtedly related to variable patient-response and suggests that certain patients require individualized therapeutic programs to obtain optimal symptomatic improvement. As evidenced by the slight, nevertheless favorable, changes observed in pulmonary function tests, the present findings confirm previous statements concerning the difficulty in effecting appreciable improvement in those factors of chronic pulmonary disease that are related to pathologic changes.

There is a general belief that chronic diseases involving the bronchi and pulmonary parenchyma are associated with the aged. Experience in this group demonstrates the fallacy of this assumption. At the time of onset of this study, only one patient was 80 years of age, six were in the 70-year group, ten were in the 60-year group, five were in the 50-year group, and three were less than 50 years of age (46, 35, and 27 years of age, respectively). These ages do not represent the ages at which the diseases first occurred or the period of time involved in their progression. For this same reason (failure to realize the time of onset of disease because of the absence of specific symptoms of pulmonary insufficiency) little reliance can be placed on statements of duration of illness. Since environmental factors and occupation appear to be contributing factors in so many pulmonary disorders, it was of interest that, in this group of patients, 65 per cent were involved in occupations (farming, painting, carpentry, and so on) in which they were continuously exposed to dust, irritants, smoke, and inclement weather.

Summary

Results obtained in this double-blind, crossover study indicate that clinically and (in some instances) statistically significant symptomatic improvement can be achieved with simple maintenance therapy in patients with complicated chronic pulmonary disorders. Many such patients experienced excellent or good improvement while receiving both medications. This suggests not only the efficacy of a single agent, but also the advantages to be gained by combining individually effective medications: oxtriphylline and glyceryl guaiacolate in this case.

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333 West State Street

Cerebral Vascular Insufficiency

On Friday, March 20, at the universally convenient hour of 4:30 p.m., you can hear a star-studded faculty participate in a symposium on cerebral vascular insufficiency. Sponsors are the Academy of Medicine of New Jersey and the State Health Department. The meeting will be in Richman's Ice Cream Plant, Route 40, Sharptown, New Jersey. Sharptown is 4 miles west of Woodstown, or 5 miles east of Pennsgrove, or 9 miles north of Salem. For further details, write to Dr. Irvin Sussman, at 151 Commerce Street, Bridgeton, N. J.

Here is a simple, effective routine for the country's commonest pulmonary cause of shortness of breath.

The Pathogenesis and Treatment of Chronic Obstructive Emphysema*

Stephen M. Ayres, M.D. / Westfield

Obstructive pulmonary emphysema is the most common pulmonary cause of shortness of breath in the United States. Chronic obstructive disease is the greatest cause of absenteeism in Great Britain. Most practicing physicians see large numbers of patients with this disease, which has been clinically diagnosed since the writings of Laennec. In spite of these facts, little is known about its cause and almost nothing is known about its pathogenesis. Very little is done about the treatment.

Laennec's observation that emphysema resembled asthma on physical examination clearly indicated the important role of obstruction in this disease. Later generations of physicians, however, stressed the widespread dilatation of air spaces and destruction of elastic tissues. Now the balance has swung back with the classic physiologic studies of Cournand and Richards. Today most students of the disease recognize the primacy of diffuse bronchiolar obstruction.

The normal bronchial tree divides successively into smaller order bronchioles. A terminal bronchiole gives rise to a respiratory bronchiole, which in turn gives rise to several second order respiratory bronchioles. In emphysema, the pathologic insult occurs at this level: the respiratory bronchiole is scarred and narrowed, alveolar walls are destroyed, and large dilated air sacs result. The common location at this level gives rise to the pathologic description of *centrilobular emphysema.*

A clue into the etiology of emphysema is gained from the observation that the lung is constantly exposed to a wide variety of air pollutants. No other organ save the skin and nasopharynx is required to survive the devastating direct contact of man's recently acquired environment. A price is paid. Chronic bronchitis was almost unknown in England until the introduction of soft coal into the economy. It is now a national tragedy. But not all who smoke nor all who inhale pollutants develop emphysema. It seems likely that, as in most disease processes, nature and nurture, heredity and environment interact. Thus, a tentative etiologic theory is that emphysema results from the interaction of a susceptible bronchial mucosa and a wide variety of air pollutants and infectious agents. The immediate pathologic response is reversible bronchial constriction.

*Aided by a grant from the National Tuberculosis Association, American Thoracic Society, and the New Jersey Medical Research and Teaching Fund, this work comes from the Seton Hall College of Medicine and Dentistry. It was read May 13, 1963 at the Annual Meeting of The Medical Society of New Jersey.

As the disease progresses, scarring replaces spasm, tissue is destroyed, permanent obstruction and air trapping progress.

Treatment is based on these three aphorisms:

(1) The primary pathologic event in emphysema is bronchial obstruction which remains, in part, reversible.

(2) The disease does *not* progress inexorably. It follows cycles - periods of relative well-being following periods of increased symptoms. Almost invariably, a respiratory infection leads to the periods of increased symptoms.

(3) Anoxia and hypercapnia, frequent in the later stages of emphysema, lead to chronic respiratory center depression with further decrease in ventilation, rise in carbon dioxide, and development of right heart failure.

A rational system of therapy would try to block the exogenous pollutant—mucosal reaction; unfortunately, this is not yet possible. Since the basic reaction cannot be blocked, it is important to manipulate the environment and prevent the mucosa from coming in contact with air pollutants. Tobacco must be forbidden; the patient's environment should be as free as possible from sulfur dioxide, automobile exhaust, dust, and smog. Infectants must be controlled by frequent treatment with antibiotics, particularly when the sputum becomes purulent. Specific allergens should be detected and eliminated.

An exception to our inability to block the pollutant-mucosal reaction may be adrenal steroids. These agents uniformly interfere with foreign protein-immune responses and have had remarkable clinical success in certain individuals with emphysema. The unfortunate side effects commonly observed with long-term systemic therapy may be obviated by the use of nebulized steroids. A method that we have found useful in selected cases is to begin therapy with an oral steroid and substitute a nebulized synthetic steroid, such as decamethasone, one week later.

The ideal is not often approached in medicine. Since the pollutant-mucosal lesion cannot be adequately blocked, symptomatic therapy is important. The cornerstone of intelligent physiologic therapy is the use of a nebulized bronchodilator, such as isoproterenol or epinephrine. It makes little sense to ingest a tablet of bronchodilator when the same agent can be directly delivered to the bronchial tree. In addition, many commercial oral bronchodilators contain sedative which may hasten the stage of alveolar hypoventilation and cor pulmonale.

As important as the choice of bronchodilator is the method of delivery. A stream of nebulized medication may be delivered by hand nebulizer, freon propellent[1], motor compressor[2], or intermittent positive pressure breathing devices[3].

The following is suggested for the routine symptomatic treatment of obstructive emphysema:

(1) Epinephrine 1 to 100, or isoproterenol 1 to 200. Ten drops in nebulizer every 1 to 3 hours depending on need. To be followed by:

(2) Alevaire®, 10 drops in nebulizer.

(3) If symptoms increase, fever develops, or sputum becomes purulent, a broad spectrum antibiotic and a good expectorant (potassium iodide, 10 drops in a glass of water 3 to 4 times daily) should be added.

The later stages of emphysema are heralded by deepening cyanosis, drowsiness due to carbon dioxide retention, and clinical evidence of right heart failure. In physiologic terms, general hypoventilation, produced by severe obstruction and increased by respiratory center depression, results in anoxemia and carbon dioxide retention. Of great importance is the knowledge that it is the hypercapnia rather than the anoxemia that produces the characteristic syndrome of drowsiness, headache, coma, and even papilledema.

Carbon dioxide tension is directly related to carbon dioxide production and inversely related to alveolar ventilation. Chronic infection and increased respiratory work increase the quantity of carbon dioxide produced, the disease itself lowers alveolar ventilation, carbon dioxide steeply rises. In addition, the tissues are increasingly anoxic. Oxygen therapy, as is well-known, permits an increase of tissue oxygen tension, but ventilation is reflexly depressed and carbon dioxide tension rises even higher. Only assisted ventilation, by intermittent positive

[1]Medihaler, Riker Laboratories, Inc.
Respihaler, Merck, Sharp and Dohme
Mistometer, Winthrop Laboratories
[2]DeVilbiss 501 Air Compressor
[3]Bird Intermittent Positive Pressure Breathing Device

pressure or tank-respirators, can augment alveolar ventilation, oxygenate tissues, and clear carbon dioxide. In the past, therapy of carbon dioxide narcosis was half-hearted, since the stage was incorrectly interpreted as irreversibly terminal. We now know that this is completely wrong. Vigorous physiologic therapy will return blood gas tensions to close to normal levels and add years of useful life to many patients.

The following program is suggested for severe obstructive emphysema with carbon dioxide retention:

(1) Vigorous application of bronchodilators, antibiotics, and expectorants.

(2) Administration of 40 per cent oxygen by either intermittent positive pressure breathing devices or a tank respirator.

(3) Digitalis and diuretics

(4) Addition of a carbonic anhydrase inhibitor (Diamox®, 500 milligrams daily) to produce a hyperchloremia and assist in bicarbonate excretion.

The great contribution of the past two decades has been the re-discovery of emphysema as an obstructive disease. Intelligent use of physiologic therapy will prolong the life of many individuals. The great promise of the future, however, lies in the unraveling of causative factors and the institution of programs of prevention. Treatment directed to the scarred and infected lung is supportive at best; the physician's treatment should be directed to those with early reversible disease. Emphysema is a disease of civilization, a disease of progress, a disease of air contamination. Certainly, further progress will lead to the irradication of this cruel malady.

121 South Euclid Avenue

Intellectual Headquarters for New Jersey Medicine

February 28, 1911 was a crisp night in Newark. A small group of New Jersey physicians crunched across the snow that lay on Washington Park. They were headed for the Public Library, the cultural center of New Jersey's bustling metropolis. Most of them rode buggies in those days, though the new fangled automobile was beginning to take hold. The genial William Howard Taft was in the White House. Except for some vague trouble in the Balkans, the world was at peace. Leaders of the profession felt that at last medicine was entering an era of scientific practice. Bacteriology was, by now, firmly established; and it was hoped that soon, for every disease, bacteria would be found, and then sera, bacteriophages, or antitoxin. Most medications still came from plants, but a few pioneers were developing complex man-made chemicals—and our state was a center for the burgeoning pharmaceutical industry.

But the doctors were still hungry for more knowledge. So they had decided to form an Academy. It would be dedicated, they agreed, "to the advancement of the science and art of medicine, to the maintenance of a medical library, and to the promotion of both public health and medical education."

Many organizations start out with high promise like that. For many, it remains a pipe dream. But this one—the Academy of Medicine of New Jersey—fulfilled the promise. Its library now approaches 50,000 volumes. Its general meetings and section meetings are gems of graduate education. Its special symposia have attracted renown.

You *can* remain on the sidelines and enjoy some of the intellectual and educational benefits that the Academy brings you. Or you can join in fellowship with the leaders of your profession. Send a note to the President, Academy of Medicine, 317 Belleville Avenue, Bloomfield, N. J., and find out how you can be one of the insiders in this intellectual and educational powerhouse of New Jersey medicine.

In this brief but practical paper, the chief of gynecology at Holy Name Hospital gives a set of useful hints on gynecologic problems in elderly women.

Gynecologic Problems in the Elderly Cardiac*

Peter J. Bonanno, M.D. / Teaneck

I have used age 60 as the lower limit of the elderly group, but remind you to remain aware of the clinical importance of *physiologic* age as compared to *chronologic* age. The "past-60" population is rapidly increasing and will continue to increase as life expectancy rises, and more attention is given to geriatric medicine. In New Jersey, almost 14 per cent of our people are age 60 and over, and almost 10 per cent are age 65 and over.

In our private practice (Dr. David Landers and myself) from 1958 through 1962, a total of 775 major gynecologic procedures were done; 14 per cent were on women over 60. This closely parallels the population trend of 13½ per cent over 60 in New Jersey; 10 per cent had some form of cardiovascular disturbance.

Spinal or caudal anesthesia was used in 89 per cent of the cases. Four-fifths of the operations were for pelvic floor relaxations, prolapse, cystorectocele, enterocele, and stress incontinence.

There are actually very few emergency gynecologic operations in patients over 60. Twisted ovarian cyst, accidental perforation of uterus, and hemorrhage from carcinoma of cervix or endometrium were about the only ones. Most of the surgery is elective. Therefore, the patients are in better physical condition than they are for general surgical procedures. With few exceptions, we have time to evaluate our patients and prepare them for the operation.

An internist can appraise the cardiac status of the patient and has time to prepare her for surgery. The nutritional state of the patient can be improved. If she has pelvic relaxations, the patient can be given estrogen creams and pessaries to keep her comfortable while waiting for surgery. For this reason, the mortality rate in major gynecologic surgery in this elderly group is surprisingly low. In our own series in this age group, *there was not a single operative death.*

The incidence and character of morbidity and post-operative complications are not appreciably different from surveys made of younger individuals. These older patients seem to complain less post-operatively than do younger women.

Early and frequent ambulation and careful attention to pre- and post-operative nutrition are essential to low morbidity.

The average hospital stay was 13 days. Our morbidity rate was 20 per cent. We get abdominal cases out of bed the same night to void. They walk about the next day. We use the suprapubic transverse incision exclusively. Vaginal cases are taken out of bed the first post-operative day. All are given a regular diet the first day after surgery. They are advised to select the foods they know they normally can digest well.

Stress incontinence is a common complaint in this age group. It is usually, but not always, associated with pelvic floor relaxations. If the relaxation is minimal, we first try the Kegel ex-

*Read May 13, 1963, Annual Meeting of The Medical Society of New Jersey in Atlantic City.

ercise along with the use of premarin or dienestrol vaginal cream, one-half applicatorful every night for 10 days; then twice a week for 3 or 4 months. If this fails and the patient has no definite cystocele or pelvic floor relaxation, we advise the Marshall Marchetti retropubic urethral suspension. If she has cystocele and pelvic floor relaxation, we try vaginal plastic surgery, reserving the Marshall Marchetti procedure for the failures, with persistence of the stress incontinence.

Urethral caruncles improve remarkably with the use of dienestrol or premarin vaginal cream on the schedule suggested above.

Urinary frequency without stress incontinence is treated with urethral dilatation and estrogen vaginal cream.

Dyspareunia and odorous non-specific discharge usually responds swiftly to estrogen vaginal cream, occasionally supplemented with one of the sulfa or antiseptic creams.

Dyspareunia due to partial atresia of the vaginal opening occuring after vaginal repairs (or in women who have not had vaginal delivery) should be corrected with a simple revision operation. This can be done in the office under local anesthesia, but preferably in the hospital with general or caudal anesthesia.

Before the patient leaves the operating room, I insert a large glass dilator and remove it in the recovery room 45 minutes later. This is followed by the use of a suitable glass dilator and the hormone cream, which the patient continues to use periodically as long as she is sexually active. In some patients the entire vaginal canal is narrowed. In these cases, I do not do the revision. I start with small dilators and the hormone cream and gradually increase the size of the dilator every two weeks until intercourse is no longer painful. Either pyrex glass dilators or Young's vaginal dilators can be used. Remember that 75 per cent of men are still sexually active after 60 years of age.

The treatment of pelvic floor relaxations—including prolapse, cysto-rectocele, and enterocele —should be individualized according to the general physical condition of the patient and the dexterity and proficiency of the individual surgeon in the various procedures available to him for the correction of these relaxations. We feel the most important factor in obtaining good results is the careful anatomical approximation of the levator ani muscles.

In recent years, vaginal hysterectomy with repair of pelvic floor has been gaining in popularity with us and in most clinics throughout the country. However, we still feel there is a place for Le Forte colpocleisis in the older women who are no longer sexually active, provided that preliminary curettage at start of the operation is negative. This applies to older, poor risk patients with complete prolapse.

At Holy Name Hospital in Teaneck, the Manchester operation for repair of prolapse is still popular and in our hands has given good results.

All patients *must* be checked for enterocele. This is especially important in women who have had previous vaginal repairs with recurrence of rectocele.

Enterocele is particularly common in cases where the surgeon has shortened the anterior vaginal wall and pulled the cervix anteriorly in his repair, thus increasing the size of the posterior culdesac and bring the cervix ahead of the levator floor. In questionable cases, we always do a colpotomy and explore the cul-de-sac with the index finger. If a deep cul-de-sac or enterocele is found, it is repaired. Ten per cent of our women over 60 had enterocele associated with pelvic floor relaxation.

Carcinoma of cervix in this age group is best treated with radium and deep x-ray; carcinoma of the endometrium with radium followed by total hysterectomy.

Post menopausal bleeding should always be investigated. In our experience about 25 per cent are due to malignancy, 30 per cent due to benign endometrial polyp, a small proportion due to atrophic vaginitis. In the remainder no cause could be found for the bleeding. Always be sure that the patient has not been taking supplemental vitamins-hormone tablets.

We recommend curettage and biopsies of cervix in all cases of post-menopausal bleeding occurring one year after the cessation of menses. A

word of caution: do not depend on the papanicolon smear in making the diagnosis of carcinoma of the endometrium. We have found it accurate for the cervix but *unreliable for carcinoma of the endometrium.*

An office endometrial biopsy or biopsy of a cervical lesion, if positive, will save the patient an extra trip to the operating room for diagnostic dilatation and curettage. I strongly advise doing it when possible.

In the presence of bleeding, a cervical polyp may be just a "red herring." Admit the patient for a dilatation and curettage and biopsies to rule out carcinoma of endometrium as cause for the bleeding.

Age should not be a deterrent to indicated gynecologic surgery. With rare exceptions, the day has passed when the reasonably healthy geriatric patient must settle for the use of a pessary for treatment of pelvic floor relaxations, or radium alone for the treatment of carcinoma of the endometrium. Weigh carefully the patient's life expectancy against what you hope to accomplish with a contemplated surgical procedure.

If the patient has an incapacitating cardiac condition, she will of necessity be off her feet most of the time. She is best treated with one of the many types of pessaries available. The internist will guide you in making your decision. Gynecologists are urged not to adopt an attitude of hopelessness just because a patient is old. We are doing these patients an injustice with such an attitude.

The judicious use of small doses of estrogen, or a combination of estrogen and testosterone in the geriatric patient, is indicated in women who show clinical evidence of being advanced beyond their years or who have multiple complaints suggestive of osteoporosis and various degenerative processes which are causing symptoms. Patients should be treated as individuals. A universal rule should not apply to all patients.

741 Teaneck Road

The Pharmacy and Health Information

The American Pharmaceutical Association and U. S. Public Health Service study to evaluate the community pharmacy as a source of family health information entered its fifth month on March 1, 1964. Reports from the 360 participating pharmacies indicate that the public is readily accepting the concept of the pharmacy as a health information center and is freely using the free literature. As of January 1, 1964, more than 1½ million pieces of health literature (supplied by over 30 cooperating professional and voluntary health agencies) have been furnished to the participating pharmacies. In October 1963, a group of 1200 pharmacy patrons were interviewed to establish opinions and attitudes of the concept *prior* to the display of the health literature. A similar group of 1200 patrons will be interviewed at the conclusion of the six-month study period in June 1964 to determine any changes in attitudes of the public *after* it has been exposed to the health information available free in the pharmacies.

The object of the study is to determine how the public accepts the idea of the pharmacy as a source of family health information and whether the program can be expanded to include all interested community pharmacies throughout the nation.

National Analysts, a well known research firm, is conducting the sampling and will evaluate the results. The American Pharmaceutical Association (operating under a U. S. Public Health Service grant) is providing all administrative services, personnel, and additional funds in the survey operation. Additional support has been given by Smith, Kline and French Laboratories and by E. R. Squibb and Sons.

This is the third in Professor Mettler's series of brief papers on the commonest presenting symptom in medicine.

Pain III*: Its Anatomic and Physiologic Substrate

Fred A. Mettler, M.D./New York

Before World War II it was well established that pain was perceived by free nerve endings. Thinking on this point was obscured by the issue of what type of pain one was really talking about and what relation it had to thermal sensation. The question was this: were different qualities of pain, especially superficial sharp pain, deep aching pain, and burning pain, all received by the same type of endings? By the time of World War II, it was felt that, whatever might be the nature of the endings involved, those fibers which conduct pain are separate and distinct from those which conduct other sensations. Emphasis had shifted away from the receptor to the conducting elements rendering intelligible many older observations, such as those of Goldscheider[1], who had found that delicate mechanical or thermal stimulation of a particular point containing only free nerve endings might elicit tactile or heat sensations whereas stronger stimulation resulted in pain. Similar observations had been made by Hoefer and Kohlrausch[2]. Apparently the slow-conducting C-fibers of nerve had a higher threshold than did those for light touch and thermal sensation, and all ended in free nerve endings. Of course, specialized nerve endings exist. Evidently, the concomitant stimulation of these tended to qualify and elaborate the sensations mediated by fibers ending freely. Data had long been available[3] to show that the quality of pain does not depend so much upon the nature of the *stimulus* as upon the nature of the *tissue* stimulated. This would seem to mean that the characteristics of the sensation, like those of orchestral music, depend upon the number and kind of devices available for activity. This issue of concerted activity is already clear in the nerve regeneration studies of Rivers and Head.[4] Head[4] observed that the awareness of poorly-defined pain returned in his denervated skin before the return of the sensation of touch. For this reason, he spoke of such pain as protopathic. When touch ("epicritic sense" in Head's terminology) returned, the unpleasant quality of protopathic pain disappeared or) as Head put it: epicritic sense inhibits protopathic. The observational facts reported by Head have been confirmed many times and are of importance in the surgical approach to pain. Every experienced neurosurgeon knows that, postoperatively, patients may complain as bitterly about parasthesias in areas that have been denervated to get rid of pain as they did before the surgery was attempted. Head's observation of the interaction of different varieties of cutaneous stimuli was an example of the integration which is intrinsic to the neural system. In the case of sensation this pattern of integration has been given form by Hebb[5]. Hebb has restated Head's observation in terms of C-fiber activity which is only believed to be painful if a well-organized pattern of activity is disrupted. The January 18, 1963 issue of *Life Magazine* carried photographs of the activity of a young Belgian cement worker shot in the face by irresponsible UN troops. This man's strong motivation led him to pursue a complex pattern of activity, of mourning his dead wife and consoling his wounded dog. which took precedence over personal pain.

Leriche[6] explained the difference between the stoicism of the soldiers in Napoleon's army and the hypochondria of the modern Parisian on the basis of unfamiliarity with suffering. He

* Based on paper presented by Dr. Mettler before the Department of Anesthesiology at Columbia University on March 28, 1963.

placed the blame for this unfamiliarity upon the use of anesthetics and analgesics. We see, however, that a more important reason is the question of the balance between the drive behind organized neural patterns and C-fiber domination. Hebb assumes that C-fiber domination arises by initiating (a) a perculiar pattern of thalamic activity or (b) excessive bursts of thalamic activity. There is no good evidence for either of these conditions, and one may inquire how in the last analysis this assumption is any different from the conventional notion of the specific conduction of pain sense. Noordenbos[7] comes closer to a realization of the factor of integration when he says, "At present one speaks of the patient's reaction to pain, but would it not be more correct to say that pain is the result of the patient's reaction" to an afferent pattern rendered abnormal by the elimination of some of the elements which are normally present. According to such a point of view, pain is the particular response to a *partial* disorganization of afferent conduction. It would not appear in the presence of a full complement of functional nerve fibers and would disappear if all the nerve fibers of an area were severed but, of course, the latter condition is difficult to achieve where overlap occurs. Noordenbos' view[7] casts new light on Head's observations and helps to render intelligible the fact that electrical stimulation of the cerebral cortex has never been able to elicit pain. Alone, and by itself, it does not explain the total loss of pain which lateral or trigeminal tractotomies sometimes (the results are capricious) induce (without destroying touch), congenital insensitivity to pain, the disregard of pain induced by lobotomy, or the fluctuation in the intensity of pain with which Hebb has been concerned.

We have seen[8] that pricking pain is apparently conducted by fibers of the A group and, although it figures prominently in much of the experimental work upon which our knowledge of pain is based, does not appear to be involved in most of the problems which trouble the clinician. "Genuine" pain usually involves tissue destruction and is correlated with free-ending C-fiber conduction. These poorly-myelinated, small fibers, which are so sensitive to local anesthetics, morphine, and alcohol, are, however, quite resistant to crushing injuries, have a tendency to overlap neighboring areas to a greater extent than do the larger fibers (which are associated with hairs and deal with touch), and evidently regenerate more rapidly than the large fibers do. Thus they tend to be active in many areas and situations where A-fibers are not. In the presence of large fibers, the central conduction of the slowly transmitted impulses of the C-fibers appears to be suppressed.

C-fibers do not appear to be able to activate the cerebral cortex in an easily localizable manner and the localization of pain is poor unless other fibers, which have precise cortical representation, are simultaneously activated. Where the painful stimulus has a particular significance for the individual (as in cases where it is interpreted as a threat to continued life, or where pain is found to have a specific value as a means of withdrawal from an undesirable existence), environmentally directed activity may be suppressed under minimal conditions of C-fiber activity; i.e., pain has dominated the situation not so much because of its intensity but because of low resistance to it. Only a relatively small proportion of the fibers in the spinothalamic system seem ever to get to the thalamus but the affective quality of pain appears to be elaborated there, presumably in the medial group of nuclei which project to the prefrontal cortex. Removal of the prefrontal cortex reduces the affective content of pain but does not alter the threshold of sensitivity to it.

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630 West 168th Street

In spite of television assurance to the contrary, proprietary acetophenetidin preparations can be seriously toxic—as the case here cited shows.

Acute Renal Failure Following Acetophenetidin Ingestion*

James J. Fennelly, M.D.
Norman Lasker, M.D. / **Jersey City**

In the last decade there have been many reports[1–9] of chronic renal insufficiency associated with prolonged acetophenetidin ingestion. The lesion has been described as interstitial nephritis and papillary necrosis. However, a recent paper[10] indicates that acute tubular necrosis can also be produced by this drug.

Here is a case of renal failure due to acute tubular necrosis subsequent to the ingestion of a large amount of a common proprietary compound containing acetophenetidin, acetyl-salicylic acid, and caffeine. The patient demonstrated methemoglobinemia with hemolysis, metabolic acidosis mimicking diabetic acidosis, and delirium.

Two hemodialysis were required before recovery.

A 40-year-old was admitted to the Jersey City Medical Center. She was an agitated, confused, incoherent, thin, middle-aged woman with Kussmaul Respiration.

Temperature was 99, pulse 140 and regular, respirations 50, blood pressure 130/80. A few coarse rales were heard over the right lower lobe. The heart was not enlarged and no murmurs were present. Neck veins were not distended at 30°. Liver, spleen, and kidneys could not be palpated. There were diffuse abdominal guarding and hypoactive bowel sounds. The deep tendon reflexes were depressed but equal.

The urine had a port wine color with a pH of 4.5, 3+ proteinuria, 4+ glycosuria (Clinitest® tablet), and 4+ acetonuria (Acetest® tablet). No cells or casts were seen in the sediment.

The blood was noted to have a dark brown color, but this did not impress the observer at the time. Hematocrit was 48 per cent, leucocyte count was 27,000 with 85 per cent polymorpho-nuclear, 5 per cent bands, and 10 per cent lymphocytes. The peripheral smear was normochromic and normocytic.

The serum acetone was 4+ in the undiluted specimen and 2+ in a 1 to 1 dilution.

Blood sugar was 389. Carbon dioxide combining power was 7.4; Blood urea nitrogen was 18. Serum sodium was 138, chlorides were 115. Potassium was 5.

On the basis of these findings, the patient was treated for diabetic acidosis with the intravenous administration of 100 units of crystalline zinc insulin as well as normal saline and sodium bicarbonate.

One hour following the insulin injection, the blood sugar was 35. At this time serum acetone was negative and the carbon dioxide combining power was still 7.4. The patient was given 50 milliliters of 50 per cent glucose intravenously and reevaluated. A repeat urine acetone test (Acetest® tablet) was positive and a ferric chloride test was positive before and after boiling, suggesting the presence of salicylates. This was verified by the arrival of the family with an empty bottle of a compound containing acetophenetidin, acetylsalicylic acid, and caffeine.

Vigorous therapy with intravenus fluids and bicarbonates was continued. The patient received a total of 352 milli-equivalents of sodium bicarbonate in the next 12 hours, but the carbon dioxide combining power increased only to 11 with the urine pH rising from 4.5 to 6.0. Eighteen hours after admission, the patient had an acute hypotensive episode which lasted 15 minutes and responded immediately to intravenous metaraminol. Over the following 20 hours, the patient was noted to become increasingly oliguric. The urine was found to contain many erythrocytes and RBC casts.

Forty-eight hours after admission, hematocrit had dropped to 38 per cent. A supravital stain of the red blood cells revealed Heinz bodies, and the urine was positive for hemosiderin. Serum salicylate level at this time was 23 and the urine obtained 12 hours after admission was reported to contain 1.6 Grams per cent of para-amino phenol following hydrolysis†.

(Conjugated N-acetyl para-amino phenol is the main excretory product of acetophenetidin[11]). See Figure 1.

*From Division of Renal Diseases and Electrolyte Metabolism, Department of Medicine, Seton Hall College of Medicine and Dentistry Jersey City.

†This test was performed by Dr. Mary Mycek.

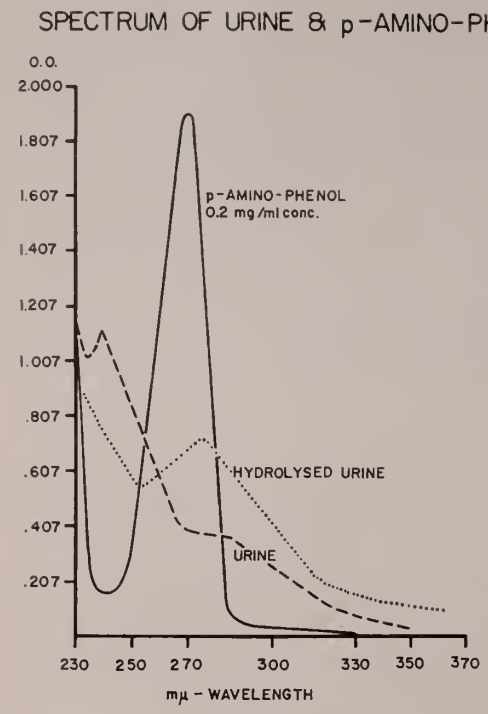


FIGURE 1

Spectrophotometric analysis of patient's urine compared with that of patient's hydrolysed urine and p-amino-phenol.

In view of the oliguria and the possible continued nephrotoxicity of acetophenetidin and salicylates, the patient was dialyzed with the artificial kidney for 6 hours. She was agitated and actively hallucinating before and during the procedure but became oriented and rational one hour after dialysis. The chemical results of the dialysis are shown in Table I.

The patient remained oliguric for 12 days when she was redialyzed because of marked weakness and a central nervous system depression. Results of this dialysis are shown in Table II.

Two days following the second dialysis the patient entered the diuretic phase and gradually improved (Figure 2). Several urine cultures were negative, and the urinalysis and blood urea nitrogen returned to normal before discharge.

A renal biopsy done on the 32nd day of her admission still showed tubular epithelial degeneration and necrosis with no evidence of pigmented casts or hemosiderin. The glomeruli were intact and there was no interstitial fibrosis (See Figure 3).

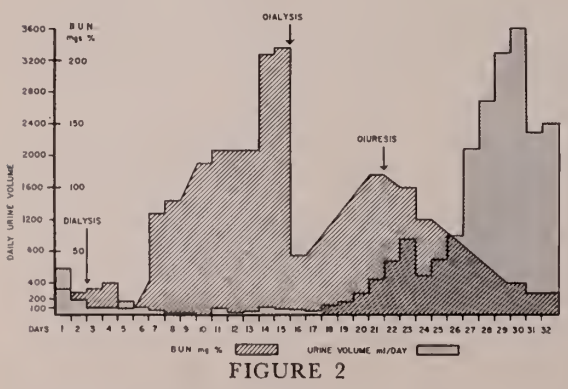


FIGURE 2

Shows fluctuations in output of blood urea nitrogen and urine volume during hospital stay.

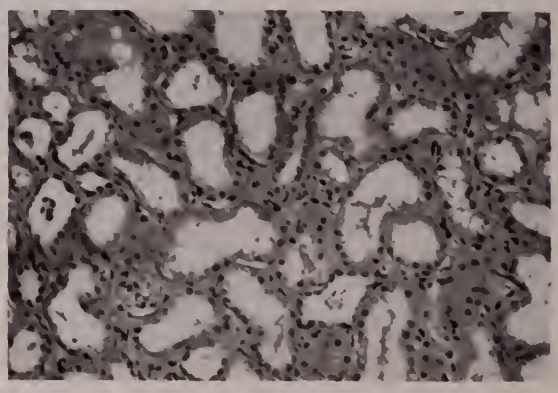


FIGURE 3

Renal biopsy taken on the 32d day after admission showing residual tubular epithelial degeneration and necrosis. Many nuclei were absent or pyknotic. Nuclear and proteinaceous debris was present in some of the tubular lumina.

Each tablet of the incriminated medication contains 195 milligrams of acetophenetidin, 211 milligrams of acetysalicylic acid, and 15 milligrams of caffeine. The patient said she had been taking APC's for headache at the rate of 4 to 6 tablets per week for several years; but denied taking more than 20 tablets during the two days prior to admission. However, the urine p amino phenol level of 1.6 at 12 hours and the plasma salicylate level of 23 at 48 hours are more compatible with the ingestion of at least 50 tablets during this interval[11,12,13].

The patient was treated with bicarbonates on the basis of a severe metabolic acidosis, indicated by the urine pH of 4.5, the carbon dioxide combining power of 7.4, and the serum potassium concentration of 5.0. The administration of sodiumbicarbonate, 352 m. eq in 12 hours was greater than a commonly recommended dose[14] of 1/3 the body weight times the extracellular deficit, but the carbon dioxide combining power and urine pH increased only to 11 and 6 respectively. This is compatible with the continued rapid production of fixed acid in a patient with decreased buffering capacity due to a preceding respiratory alkalosis[16].

The frequent similarity of salicylate poisoning and diabetic acidosis has been pointed out[16] by many authors[17]. The easiest method of distinguishing the two is a ferric chloride test of the urine which is positive in both, but becomes negative after boiling in diabetic acidosis because of the volatility of acetoacetic acid[17]. The mechanism of the production of hyperglycemia and ketosis in salicylate poisoning is thought[15] to be a combination of increased glucose demand, interference with glucose utilization by poisoning of cellular enzymes, and increased adrenocortical steroid production.

No definite conclusion can be offered as to the cause of acute tubular necrosis in this patient. Fifteen minutes of hypotension terminated by a single injection of metaraminol would not ordinarily be sufficient to produce tubular necrosis. Several cases of oliguria have been described with salicylate poisoning, but we could find only one case[22] with histologic evidence of tubular necrosis. This was a post-mortem examination with evidence of both glomerular and tubular destruction. Bing[23] has shown that methemoglobinuria will produce acute tubular necrosis in the dog when the animal has previously been made acidotic. This did not occur with hemoglobin or myoglobin and was not necessarily associated with methemoglobin precipitation in the tubules. Acetyl-salicylic acid and acetophenetidin produced severe acidosis and methemoglobinemia in this patient. Since this combination of medications is so widely used, one would expect overdosage with these proprietary combinations to be a more common cause of acute renal failure than hitherto reported.

The patient developed an acute hemolytic anemia with a fall in hematocrit from 48 to 38 per cent and the excretion of hemosiderin in the urine. The mechanism of acetophenetidin induced hemolysis is still not clear. Reduced glutathione (GSH) plays an important role[24] in the maintenance of the integrity of the red cell membrane[25]. Beutler[26] and Kimbro et al[27] noted a decrease in red cell GSH levels after exposure to acetophenetidin. However, McGibbon *et al*[10] and Muirhead *et al*[28] found normal GSH levels in patients with phenacetin induced hemolysis but demonstrated autoantibodies on the red blood cells. Acetophenetidin can readily produce hemolysis in patients with glucose-6-dehydrogenase deficiency[29]. No deficiency of glucose-6-dehydrogenase could be demonstrated in our patient when her blood was tested by a modification of the brilliant cresyl blue reduction test[30] and the glutathione stability test[26], 2 weeks and 7 months after the hemolytic episode.*

The patient was dialyzed on two occasions for entirely different reasons. The first dialysis was to reduce the blood level of acetophenetidin and salicylate which were apparently still producing methemoglobinemia and acidosis 48 hours after admission and acting as a nephrotoxin. The second procedure was indicated because of the clinical deterioration in the patient's condition consisting of marked weakness and CNS depression after 19 days of oliguria.

Summary

A case of acute renal failure resulting from the ingestion of a common proprietary compound containing acetophenetidin, caffeine, and acetylsalicylic acid is presented. The patient developed methemoglobinemia, hemolytic anemia and severe metabolic acidosis mimicking diabetic acidosis. Two hemodialysis were performed before recovery.

TABLE I
FIRST HEMODIALYSIS

	Before	*After*
Plasma salicylate	23 mgm%	5 mgm%
Serum sodium	129 mEq/L	134 mEq/L
Serum potassium	3.3 mEq/L	3.9 mEq/L
Serum chloride	72 mEq/L	95 mEq/L
Blood urea nitrogen	29 mgm%	4 mgm%
CO_2 Combining power	11.5 mmol/L	26 mmol/L

TABLE II
SECOND HEMODIALYSIS

	Before	*After*
Blood urea nitrogen	220 mgm%	39 mgm%
CO_2 Combining power	12 mmol/L	22.5 mmol/L
Serum sodium	132 mEq/L	135 mEq/L
Serum potassium	5.6 mEq/L	4.5 mEq/L
Serum chloride	85 mEq/L	100 mEq/L

A detailed bibliographic listing of 30 citations appears in the authors' reprints.

*These tests were performed by Dr. Milton Corn.

Medical Center (Dr. Lasker)

STATE ACTIVITIES

Taxability of Practice Groups

Your AMA has recently filed a brief with the Commissioner of Internal Revenue protesting some proposed new regulations that concern medical practice groups. Likewise, your State Society has made its displeasure known in conjunction with the New Jersey Bar Association at hearings held recently in Washington, D. C. Under current legislation, New Jersey physicians are able to incorporate in an effort to qualify as corporations for federal tax purposes. However, the Internal Revenue Service has prepared new regulations (which would have the force of law) to nullify the equality of tax treatment between corporations and professional associations sought by the passage of professional service corporation acts.

Over the signature of Dr. F. J. L. Blasingame (the AMA's executive vice president), the AMA has submitted a tightly reasoned brief, pointing out that such regulations would

(1) frustrate the intent of Congress to establish a system of taxation having uniform application to all taxpayers;

(2) invalidate state laws adopted to assure such equality;

(3) transfer legislative functions from the Congress to an executive department—in this case, the Treasury;

(4) ignore that current Treasury regulation which says that the word "corporation" can include associations;

(5) disregard the previous rule that local laws determine legal relationships and corporate status;

(6) arbitrarily and adversely prejudge every professional service organization;

(7) disregard the realities of modern business practice.

The Internal Revenue Code, Dr. Blasingame points out, "does not distinguish between corporations on the basis of their activities. Revenue rulings and case law make it clear that the word 'business' embraces the activities engaged in by professional men . . .

". . . there are numerous corporations incorporated under State statutes which conduct their activities in the manner in which physicians and lawyers would conduct their activities if organized as professional corporations. There are corporations of a professional nature engaged in scientific research . . . organized with many limitations similar to those which the Revenue Service has indicated would prevent corporate status for federal tax purposes in the case of medical and legal professional corporations. Yet such organizations have qualified under all provisions of the Internal Revenue Code and pension plans established by them have been held to qualify for tax exemption.

". . . (by this proposed ruling) . . . professional corporations are singled out for discrimination . . . there is no justification, legal or otherwise, for discrimination against the professional man.

"The American Medical Association objects to the proposed regulations. Since every corporation organized under State law has hitherto been judged on the merits insofar as corporate status for federal tax purposes is concerned, the Revenue Service should continue to do so . . ."

AMA Membership Categories

From time to time, we are asked to explain the AMA's five membership categories. In brief, here is the story. The American Medical Association has five membership classifications:

1. Regular Members
2. Service Members
3. Associate Members
4. Affiliate Members
5. Honorary Members

Only the first two categories (generically called *active* members) may vote. Here is what these classifications mean.

1. *Regular members* are physicians eligible to vote in constituent state medical associations. (The Medical Society of New Jersey is an original constituent of the AMA.) Some regular members are dues-exempt because of retirement, hardship, or training status. This does not affect their right to vote.

2. *Service members* are the regularly commissioned medical officers of the U. S. Army, Navy, Air Force, and Public Health Service; also reserve medical officers on extended active duty; also permanent members of the Veterans Administration Department of Medicine and Surgery; and former service members lawfully retired and not gainfully employed. Service members are dues-exempt but can vote in AMA elections.

3. *Associate members* are (a) physicians certified by the appropriate Surgeon General as being on temporary active duty; and also (b) regular members of constituent state medical societies who, for any reason, are ineligible for regular AMA membership. Associate members are exempt from AMA dues but may not vote in AMA elections.

4. *Affiliate members* are elected to that status by the AMA House of Delegates. This is the only category of AMA membership that includes non-physicians. The "affiliate" classification includes certain dentists, pharmacists, biologic scientists, and teachers of various biologic sciences who are not eligible for regular membership. It also applies to American physicians engaged in educational, philanthropic, or missionary work outside the continental limits of the USA; and to physicians who belong to chartered national medical societies of countries adjacent to the USA.

5. *Honorary members* are in a class intended for physicians of foreign nations who have risen to pre-eminence in medicine and who attend an AMA convention. They may be elected at the convention to Honorary Membership by the House of Delegates on nomination of the Board. Honorary members may attend meetings of the Postgraduate Assembly, but may not vote or hold office in the AMA. They are not required to pay dues.

The Universal Medical Symbol



Look at the symbol pictured here. It is the star of life, the asterisk of health. This AMA style caduceus* is imprinted on a stylized 6-point "star" inclosed in a hexagon. It is a signal to look promptly for information about the health, life, idiosyncracies, or disability of the person wearing it or carrying it. Developed by the American Medical Association last year, it is freely offered to manufacturers and distributors. You will see it on metal, plastic, or cardboard. It may appear in any size, color, or place. It may be on a medallion hung around the neck or it may be attached to a bracelet. It may be on a card in wallet or purse. If you see it, look elsewhere on the person for more detailed medical information.

Many doctors will want to distribute medical signal identification cards to their patients. You get these from the American Medical Association at 535 North Dearborn Street, Chicago, Illinois, 60610. The cost—to you—is $5 a thousand cards. Each card has space for emergency and identifying information. On this card, the patient can indicate what medication he takes regularly and can list his allergies, immunizations, and disabilities.

*Linguistic purists distinguish between the two-snake caduceus and the one with only a single serpent. The AMA uses the one-snake type, which is the staff of Aesculapius. The stick with a pair of snakes entwined on it is, technically, the staff of Mercury, not Aesculapius. The Army of the United States, as all readers of this footnote must know, uses the two-snake caduceus. The word comes from the Greek *kedux*, meaning herald. Mercury was the gods' messenger boy, hence kedux. Since the snake sheds his skin annually, the serpent has been the traditional symbol of healing (renaissance!); but to the classicist, one snake is enough.

OBITUARIES

Dr. Julian Cohen

A heart attack suddenly took the life of Dr. Julian Cohen, one of Paterson's leading cardiologists. Dr. Cohen died on January 21, 1964 at the age of 55. He was born in Paterson, and he served the people of that area all his professional life. He received his M.D. at Bellevue in 1933, and after completing his residency, entered the private practice of internal medicine. He was a Board Diplomate in that speciality. He served the Passaic County Medical Society in all offices, becoming eventually the president of that component society. He also served as president of his county Heart Association. He was on the medical staff at Paterson General Hospital.

Dr. Evelyn Holt

One of New Jersey's leading women physicians, Dr. Evelyn Holt, died on New Year's Eve at her summer home in Maine. Born in New York City in 1898, she received her baccalaureate degree from Wellesley in 1919 and her M.D. from Cornell in 1924. She came to Union County, New Jersey, and soon thereafter affiliated herself with the Overlook Hospital in Summit. She served that hospital in internal medicine at all levels from clinical assistant to attending cardiologist; and for some years was president of the senior staff organization at Overlook. Dr. Holt was a diplomate of the American Board of Internal Medicine, a Trustee of the Kent Place School, and active in committee work for the Union County Medical Society. She retired from active practice early in 1963.

Dr. Paul Livingston

One of Essex County's senior practitioners, Dr. Paul Livingston, died on January 3, 1964 at the age of 83. He was born in Pittsburgh during the presidency of Benjamin Harrison. In 1910 he was graduated at the Jefferson Medical College of Philadelphia; and after interning in his native city, came to New Jersey. He did private practice in the Oranges for more than half a century. In 1913 he was one of the first doctors on the staff of St. Mary's Hospital in Orange, and established the laboratory there. He was affiliated later with both the East Orange General and the Orange Hospital Center. He was a general practitioner, and proud of it.

Dr. John E. Runnells

New Jersey lost one of the country's best known phthisiologists and hospital administrators with the death of Dr. John Edmund Runnells on January 3, 1964. Born in Canada in 1876, he received his M.D. degree at Tufts in 1908. After interning in Boston, he took a residency in chest diseases at the Massachusetts Tuberculosis Hospital and then crossed the line into New Hampshire serving as clinical director, later Superintendent of the State Sanatorium there. In 1912, the freeholders of Union County, New Jersey, decided to construct a tuberculosis hospital in Berkeley Heights and invited Dr. Runnells to establish and operate it. It was known as Bonnie Burn and was shaped by Dr. Runnells in accordance with his ideas of what the modern sanatorium should be. He devoted nearly all his professional life to this institution, which was renamed the John E. Runnells Hospital after his retirement in 1959. Dr. Runnells was active in the Union County Medical Society and served a term as its president.

Dr. John S. Van Winkle

Dr. John Shaw Van Winkle, chief of staff of the Paterson Eye and Ear Infirmary, died on December 29, 1963 after a short illness. Born in Paterson in 1889, he received his doctor's degree from the University of Pennsylvania in 1916. He served in the Navy Medical Corps during World War I, and then did graduate work in ophthalmology. He devoted himself to that speciality from 1923 until his death forty years later. He served several terms as chief of staff at the Paterson General Hospital. He was ophthalmic consultant to several other hospitals in the Passaic-Morris County area.

BOOK REVIEWS

Accident Surgery. By Herbert F. Moseley. New York, 1962, Appleton-Century-Crafts. Pp. 242. Illustrated. ($10.00)

This book represents the experiences of a well-integrated team of specialists on the accident service of Montreal's Royal Victoria Hospital. Its editor, Dr. H. F. Moseley, is a distinguished and articulate author of many textbooks in the field of orthopedic and traumatic surgery.

This is a well-illustrated documentary of the modern technics used by various specialties in the handling of the multi-injured victims of an alarming epidemic of high speed mechanization of industry and that high velocity ground missile: the traffic vehicle. It includes thoughtful chapters on blood volume in injury, craniocerebral injuries, surgical treatment of facial injuries, and avulsing injuries of the hand. This book should be required reading for all practitioners of medicine, not just for those involved in the emergency treatment of accident victims. *Accident Surgery* will be a valuable addition to the lean bookshelves for the contemporary practitioner. Sidney Keats, M.D.

Resistance of Bacteria to the Penicillins. Edited by A. V. S. De Reuck and Margaret P. Cameron. Boston, 1962, Little, Brown and Company. Pp. 125. 14 illustrations. ($2.95)

This small volume is a summary of five papers and a general discussion of the subject which occurred at a conference of workers (mostly British) dealing with the resistance of bacteria to penicillins. Included are the mode of action of penicillin, the types of resistance to different penicillins, penicillinase, and penicillin resistance to staphylococci. These papers are principally presentations of work to confreres in basic research (bacteriology, biochemistry, genetics) and clinical aspects are not particularly stressed, although some valuable conclusions are available for the clinician.

This small monograph permits the exchange of views by the participants and invites more expression of opinion than is found in usual manuscripts. This publication appears less than one year after the time of the conference while material is still new; much earlier than could be expected. There is thus available to other interested investigators a source of very current material and opinion.

For the clinician, this monograph provides an interesting, exciting, attractively readable, brief, and comprehensible entrée (or return) to basic science type of experimentation and investigation which he can use as a foundation in making decisions in an area of clinical practice which sometimes presents a very vexing therapeutic choice. Jacque B. Wallach, M.D.

Activities of Surgical Consultants. Edited by B. Noland Carter, M.D. Washington, D. C., 1962, Department of the Army. Pp. 621. 104 illustrations, 31 tables. ($6.50)

This publication, from the office of the Surgeon General, is the first volume of a series on Surgery in World War II.

This is a historically very valuable work. The first section discusses surgical consultants in the zone of the interior working out of the Surgeon General's office. This had to do mainly with administrative problems, and it reflects the vast number of extensive and important decisions that had to be made and how they were made. The chapter that has to do with the handling and distribution of penicillin is only one of the many successful administrative procedures that were carried out.

There is material here on the surgical consultants in the Service Commands. For those of us who had firsthand knowledge of its success, this raises the question of the necessity for, and the accomplishments of, these positions. The reports of the various consultants (as outlined under the Service Commands)

are not for the most part too impressive, nor was the type of problems that they sought out for handling of any particular magnitude, although the reading and documentations of the individuals involved are perhaps worthy of the effort. The chapters on surgical consultations to Field Armies and Theatres of Operation are more convincing. While, in these areas, the consultants may have seemed remote, their overall supervision and reports to the Surgeon General's office were undoubtedly invaluable, although their value to the individual hospital itself was oftentimes questionable.

The activities of surgical consultants, in the blood program and for the administrative offices on a permanent basis in the Surgeon General's office, was probably one of the brightest spots in the entire operation of the Army Medical Corps during the war.

Daniel F. Featherston, M.D.

Visual Problems in Aviation Medicine. By Armand Mercier, M.D. New York, 1962, Macmillan. Pp. 120. ($6.00)

This is a collection of the papers presented at a meeting of the NATO advisory group for aeronautical research and development. Except for the active flight surgeon or the researcher in aviation medicine, this book has but limited appeal and value. Such items as examination standards in selection of flying personnel in the RAF, wearing of contact lenses by flyers (wherein nitrogen bubbles may or may not accumulate behind the lens), the arrangement of instruments and dials in the cockpit are not of great interest to the average ophthalmologist.

Such matters as "space myopia" and its attending visual consequences at high speeds; the limitations of man in the increasingly mechanized, transistorized, and "quick-reaction-time;" the subtle effects on vision and coordination of even mild anoxia are significant and, indeed, frightening. Other than these few chapters, I do not feel that this book is necessary to your library. S. Jerome Greenfield, M.D.

Cancer. Ed. 3. L. V. Ackerman, M.D. and J. A. del Regato, M.D. St. Louis, 1962, Mosby, Pp. 1296,, 783 illustrations. $29.50).

In every sense this is a big book. It has the weight and size of an unabridged dictionary. It is big in scope, and it concentrates on the most pressing medical problem of our age. It includes an unusual and compact monograph on research by Michael Shimkin. The discussion of pathology is lucid and will aid any clinician in his understanding of cancer. Chapters on radiotherapy and surgery (the latter by Harvey Butcher) are valuable, in-the-round presentations of those subjects. The text then reports on cancers of each body region, reviewing diagnosis, pathology, and treatment. Cancer is on the ascendancy, and we might as well face the dreadful fact that one in every five persons will develop a malignancy some time in his life. Every doctor of medicine has a responsibility to know as much as possible about this; and this almost encyclopedic third edition of Ackerman-del Regato will give him a solid platform for further understanding.

Ulysses Frank, M.D.

Disability and the Law. Edited by G. C. Manning, Jr., M.D. Baltimore, 1962, Williams and Wilkins. Pp. 58. ($3.50)

The Congress of Neurologic Surgeons here releases the report of a committee to study ways of evaluating neurologic disability. They come to the pessimistic conclusion that there is no objective yardstick for appraising disability and that such evaluations are administrative or legal concepts best left to nonmedical personnel. The book includes eight short chapters covering the psychology of the plaintiff, the anatomy of testimony in personal injury cases, the motivations of physicians and claimants, the juridical concept of disability, and the relationship of disability to preceding trauma. The text includes some pithy advice to court room novices and much meaningful, if somewhat philosophical, discussion of the basic problems involved. These essays provide thought-provoking and discussion-provoking ideas in the whole field of forensic medicine. Herbert Bochin, M.D.

ABSTRACTS

ON TUBERCULOSIS AND OTHER RESPIRATORY DISEASES. ISSUED BY THE NATIONAL TUBERCULOSIS ASSOCIATION

MARCH, 1964 • VOL. XXXVII, NO. 3

SPONTANEOUS ALVEOLAR RUPTURE AT BIRTH

Pneumothorax may occur with the first few breaths of life, presumably due to aspiration of foreign material. Although many infants recover spontaneously, some may require special measures—oxygen breathing or prompt aspiration.

Spontaneous pneumothorax is more common in the newborn period than in any other time of childhood. Since it is one of the few treatable causes of respiratory difficulty in the early days of life, the predisposing factors, clinical findings, and rationale of therapy should be understood.

Of 15 infants with the diagnosis of spontaneous pneumothorax seen in this hospital from 1955 to mid-1962, only two were less than 2.5 kilograms birth weight. Four infants had gestational ages of 42 weeks or more.

In seven of the 15 infants the signs of pneumothorax were clearly evident in the delivery room, which suggests that the collapse occurred with the first few breaths. Three of the seven were meconium stained. The remaining eight infants were symptomatic within the first 24 hours of life and two of these were meconium stained.

Chest X-rays Taken

The possibility of aspiration of blood or meconium as a predisposing event was clear in eight of the 15 infants, and the aspiration of mucus could not be ruled out in any infant. Infection was considered possible in two infants who had infiltrates in the lungs after reexpansion of the collapsed lobes.

Chest films were taken to aid in the diagnosis of all the infants. In only three was the diagnosis strongly suspected before the films were available. Irritability and restlessness were often present. Periodic breathing occurred with large pneumothoraces, and convulsions occurred in one infant who subsequently died.

Four of the 15 infants died, one with tricuspid atresia, one with hyaline membrane disease, and two from their pneumothoraces.

Three of the 11 infants who recovered were treated by water-seal suction applied through a catheter inserted through the chest wall. Deterioration of the infant's condition, characterized by increasing cyanosis, irritability, and periodic apnea, was the indication for aspiration of the air by sustained suction. In the survivors, immediate improvement was apparent after the application of suction. The eight infants who were only mildly ill cleared within hours or up to nine days in incubators. Antibiotics were used when there was any possibility of infection.

Inflating the Lung

The first breath of the newborn infant poses a unique mechanical problem for two reasons: (1) the development of high transpulmonary pressures and (2) the uneven inflation of the airless lung.

Introduction of air into the airless lung requires the application of high pressures (up to 100 cm.H_2O) to overcome the viscosity of

VICTOR CHERNICK, M.D., and MARY ELLEN AVERY, M.D., *Pediatrics,* November, 1963.

fluid in the airway and the forces of surface tension, and to stretch the lung parenchyma. As the lung expands the muscles are no longer in a position to maintain a high transpulmonary pressure.

If only one alveolus opens in the initial expansion and the rest of the lung remains atelectatic, there is no pressure difference across the unaerated portion of the lung because the pressure is transmitted through the lung tissue. However, the pressure inside the aerated alveolus is at approximately atmospheric pressure and the pressure surrounding the alveolus is below atmospheric pressure. The large pressure difference across this single alveolus is of sufficient magnitude to rupture it if prolonged for a critical period of time.

Inflation Uneven

The normal airless lung does not inflate evenly. Groups of alveoli rapidly become fully expanded while other areas of the lung remain atelectatic. Inflation of the atelectatic lung *in vitro* clearly demonstrates this serial or sequential opening of ventilatory units.

The pertinent question is why every infant does not have a spontaneous pneumothorax with his first breath. Presumably initial expansion of the lung is rapid and smooth in the vast majority of newborns. Cineroentgenograms of the first breath show that the lungs of the normal newborn inflate promptly. Physiological observations show that a full functional residual capacity is achieved during the first minutes of life, and that the volume of a cry within the first 18 minutes of life is about 77 per cent of that on the third day of life. Once expanded, an alveolus rarely ruptures in a normal lung. This is largely because of the inability of the diaphragm and chest wall to create transpulmonary pressures high enough to rupture the lung.

If there is obstruction to portions of the atelectatic lung this might lead to a prolongation of high pressures across aerated alveoli and could lead to their rupture.

Deaths Preventable

Deaths from pneumothorax in the absence of serious underlying disease should be preventable. Once it is known that a pneumothorax or a pneumomediastinum is present, the infant should be on special observation, with pulse and respirations recorded every 15 minutes because of the rapidity with which tension phenomena may develop. Early and frequent small feedings may be useful in preventing vigorous crying. Limited numbers of observers carrying out physical examinations may prevent the one hard cry which produces the tension phenomenon. The precaution of a No. 18 needle, syringe, and three-day stopcock by the bedside, and frequent observations seem justified for all infants with pneumothorax or pneumomediastinum.

Any sudden change in vital signs should alert the physician to the possibility of air under tension, and if there is deterioration in the clinical status, needle aspirations should be done. Continuous drainage is indicated when pleural pressure is positive.

Some babies have a pneumomediastinum or pneumothorax which is not in communication with the airway, or under pressure. However, the size of the loculated pocket of gas does interfere with respiratory exchange. In this situation 100 per cent oxygen inhalation can be utilized to hasten the absorption of gas from the pocket. Prolonged exposure to oxygen would, of course, be contraindicated in the premature infant unless cyanosis were present. It must be remembered, too, that the use of oxygen for a prolonged period of time enhances the production of atelectasis for the same reason it enhances the rate of removal of loculated gas if the patient does not take a deep breath periodically.

New Jersey Tuberculosis and Health Association
15 East Kinney Street, Newark 2, New Jersey



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Average Adult Dosage: One rounded teaspoonful of Metamucil powder (or one packet of Instant Mix Metamucil) in a glass of cool liquid. Metamucil powder contains equal amounts of refined, purified psyllium and dextrose furnishing 14 calories and is available in containers of 4, 8 and 16 ounces.

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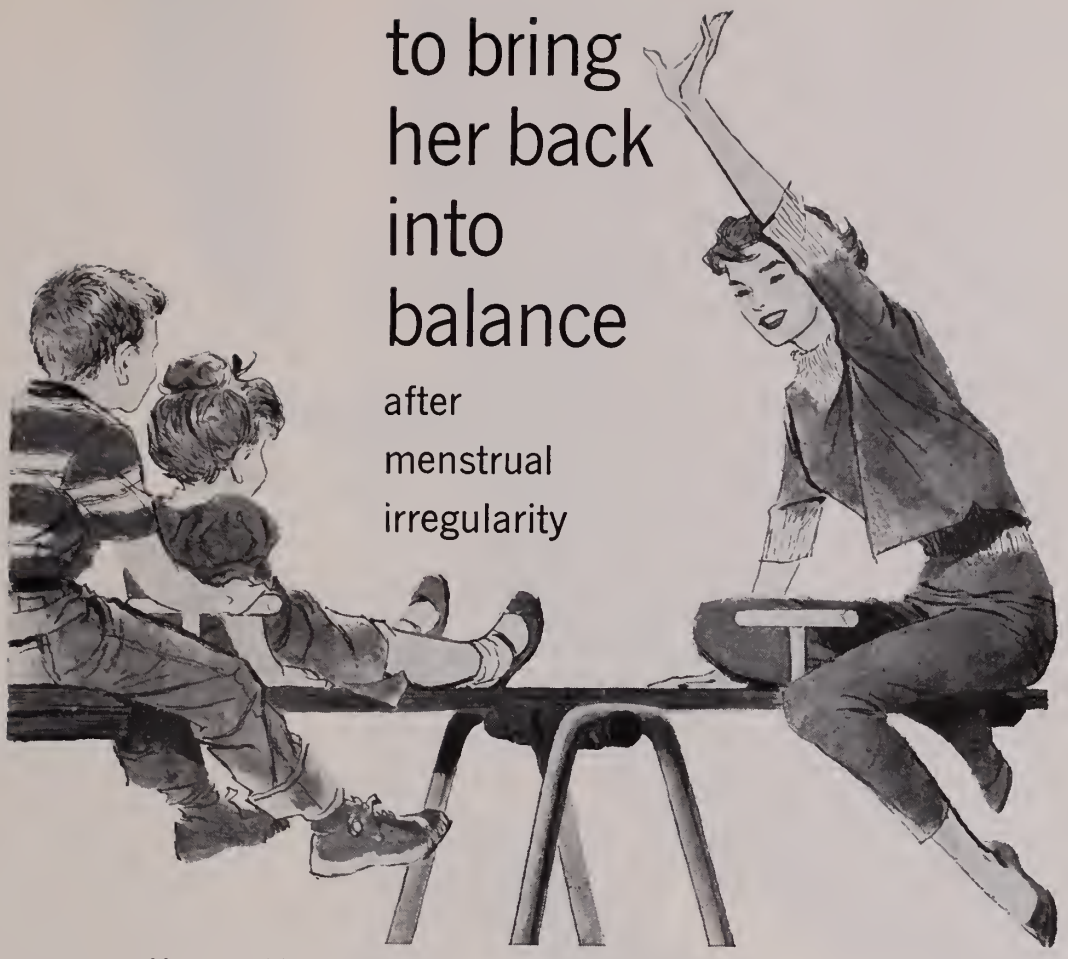
Brief Summary of Principal Side Effects and Cautions

Side effects (chiefly nervousness and insomnia) are infrequent, and usually mild and transitory. *Cautions:* 'Eskatrol' *Spansule* capsules should be used with caution in the presence of severe hypertension, advanced cardiovascular disease, or extreme excitability. There is a possibility, though little likelihood, of blood or liver toxicity or neuromuscular reactions (extrapyramidal symptoms) from the phenothiazine component in 'Eskatrol' *Spansule* capsules.

For complete prescribing information, please see *PDR* or available literature.

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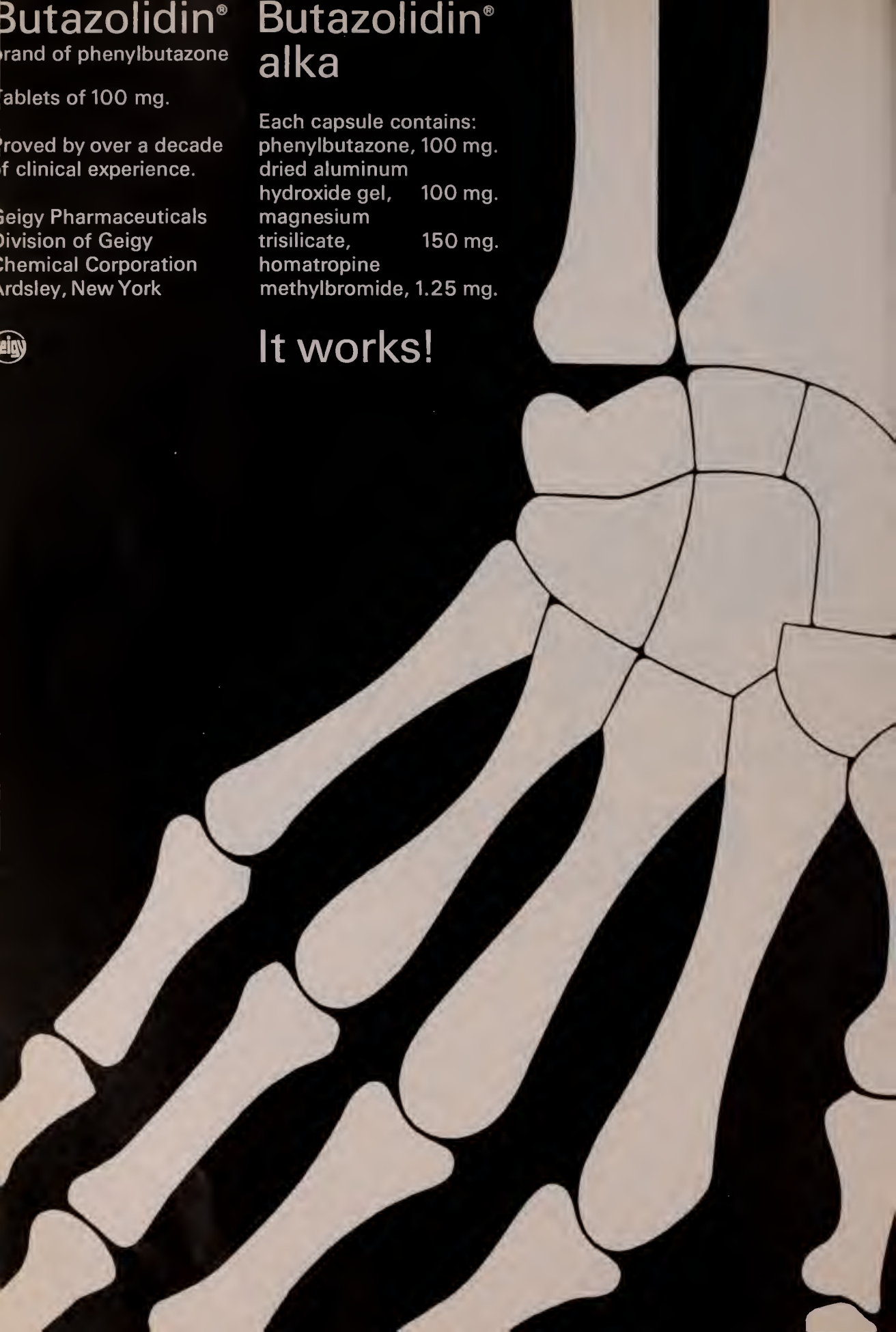
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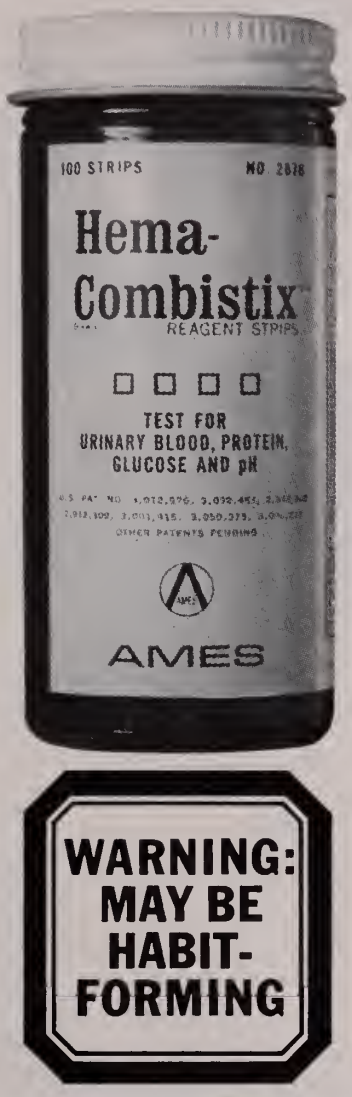
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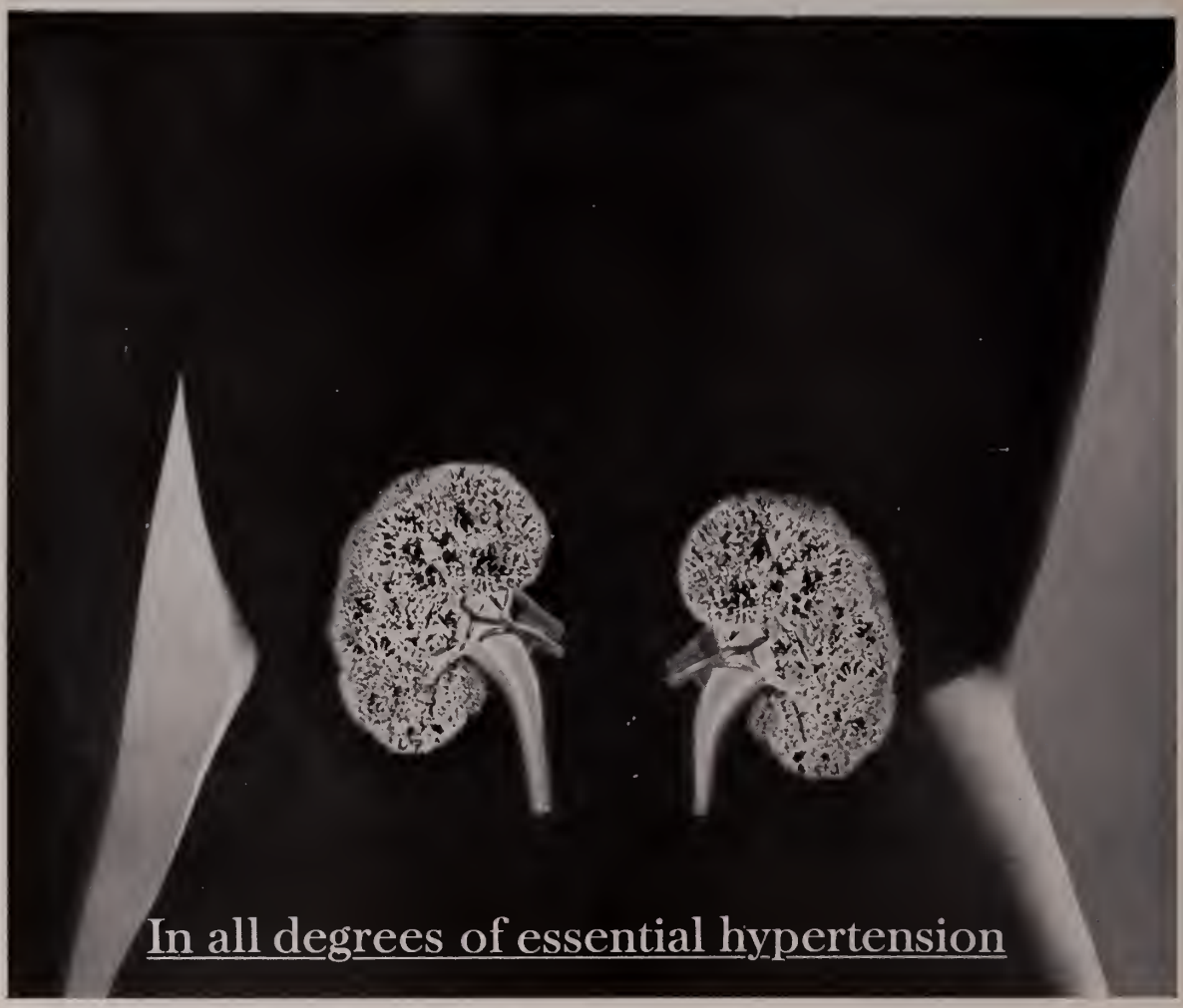
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References: (1) Moyer, J. H., and Heider, C.: Am. J. Cardiol. *9*:920 (June) 1962. (2) Brest, A. N., and Moyer, J. H.: Pennsylvania M. J. *63*:545 (Apr.) 1960. (3) Berry, R. L., and Bray, H. P.: J. Am. Geriatrics Soc. *10*:516 (June) 1962. (4) Hutchison, J. C.: Current Therap. Res. *4*:610 (Dec.) 1962. (5) Feldman, L. H.: North Carolina M. J.: *23*:248 (June) 1962.

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Bibliography: 1. Williams, R. H.: Textbook of Endocrinology, Ed. 3, Saunders, Philadelphia, 1962, p. 610. 2. Gordon, E. S.: Metabolism 11:819, 1962. 3. Grodsky, G. M. et al.: Metabolism 12:278, 1963. 4. Sadow, H. S.: Metabolism 12:333, 1963. 5. West, K. M. and Tophoj, E.: Metabolism 10:689, 1961. 6. Yalow, R. S. and Berson, S. A.: Diabetes 9:254, 1960. 7. Weller, C. et al.: Scientific Exhibit, A.M.A., June 1962. 8. Weller, C. et al.: Metabolism 11:1134, 1962. 9. Radding, R. S. et al.: Metabolism 11:404, 1962.

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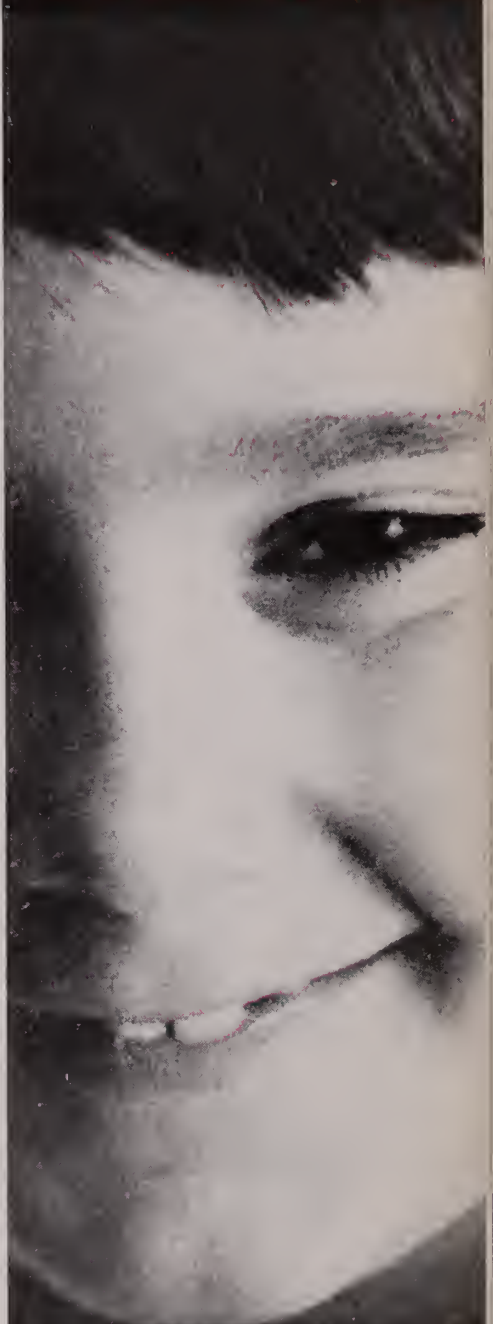
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THE JOURNAL
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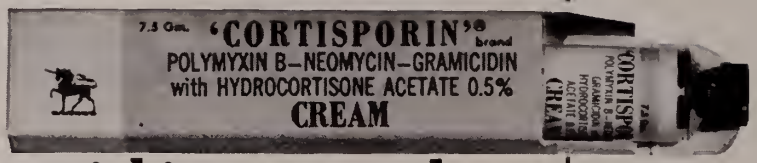
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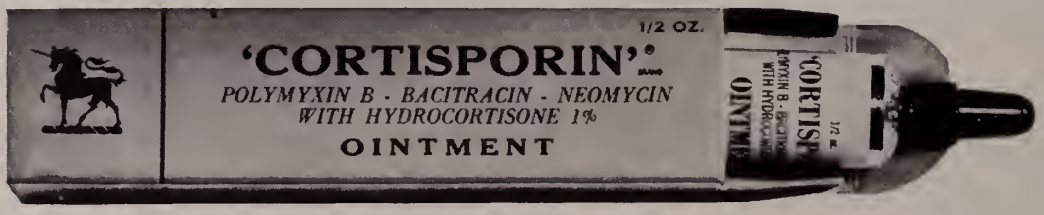
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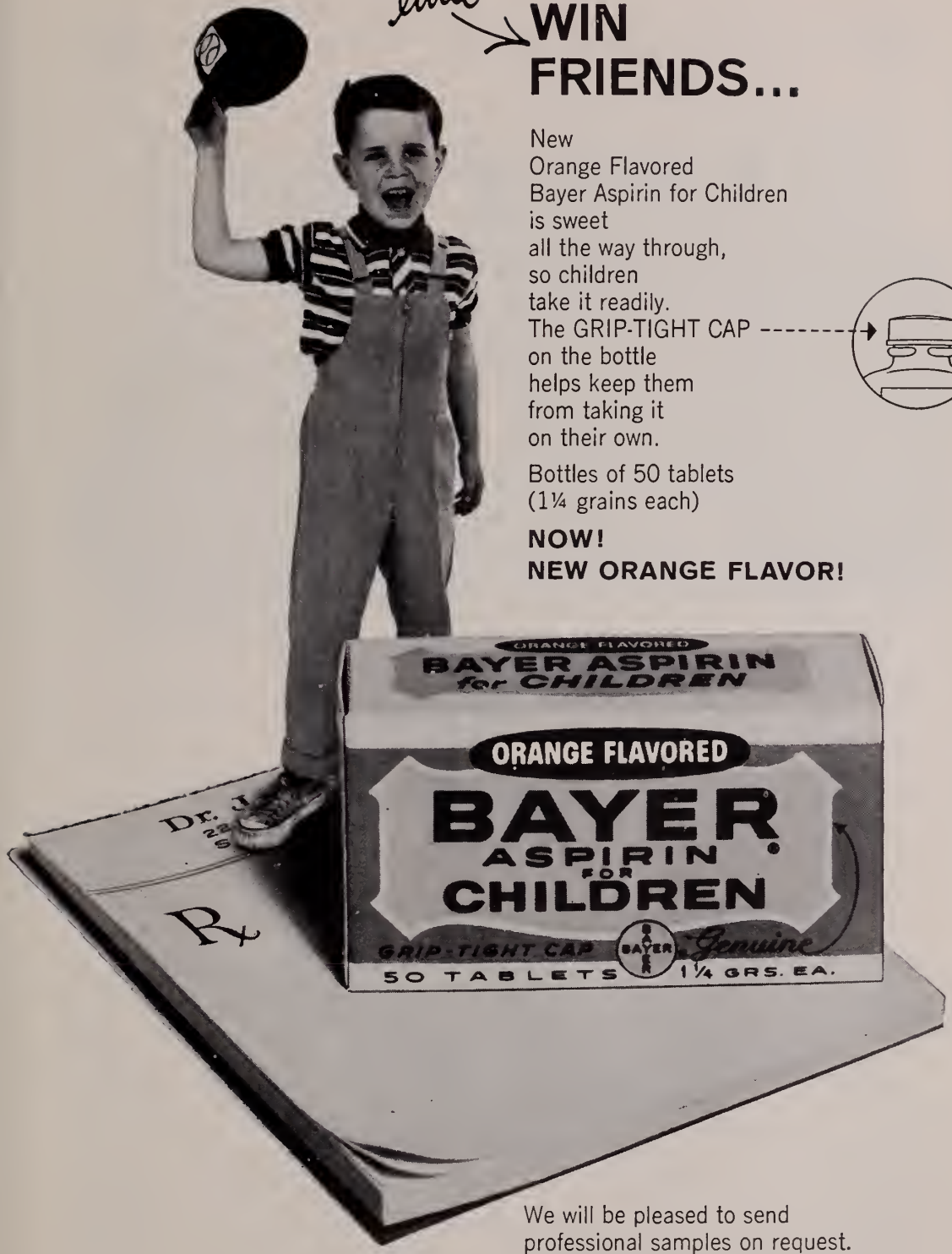
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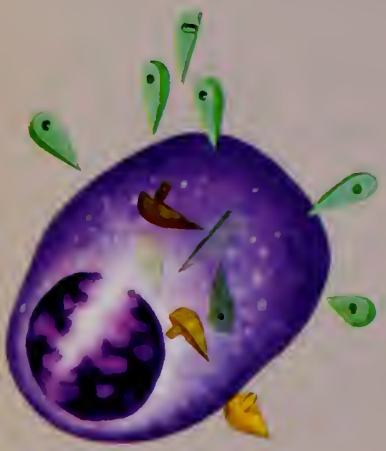
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*Cohen, et al: J.A.M.A., 165:225, 1957.

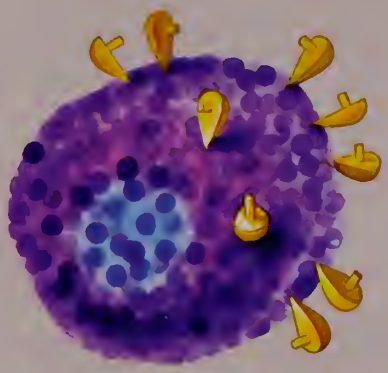
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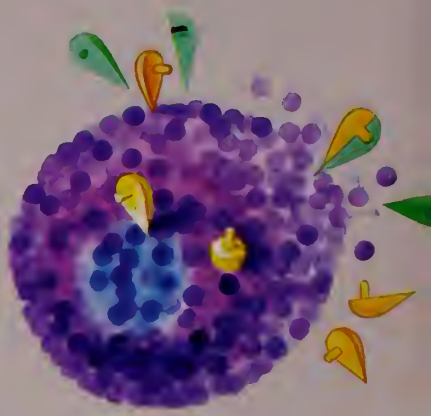
It is generally accepted that a complex antigen-antibody reaction underlies allergy. The reaction may be visualized in this simplified graphic form:



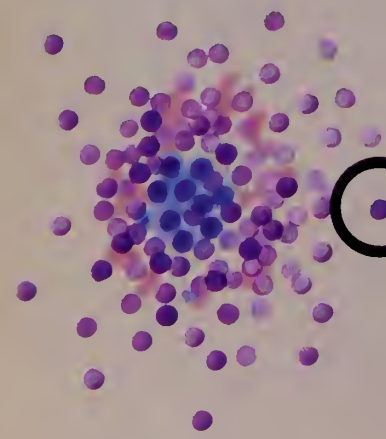
At first exposure to antigens (green) specific antibodies (yellow) are formed chiefly by plasma cells.



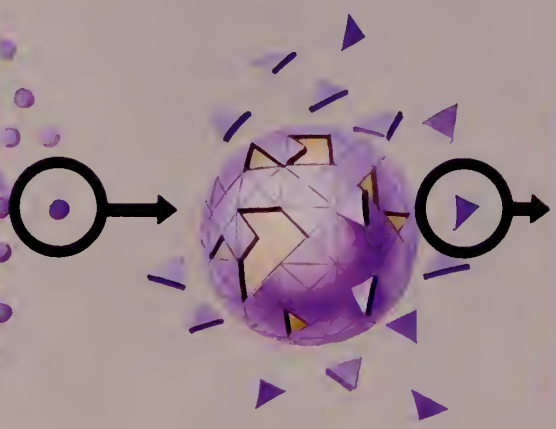
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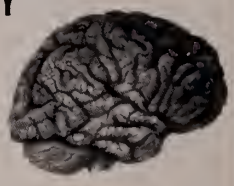
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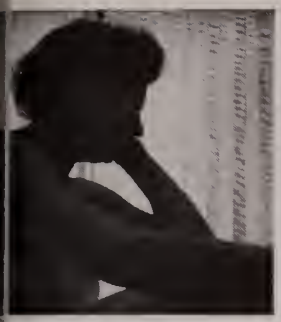
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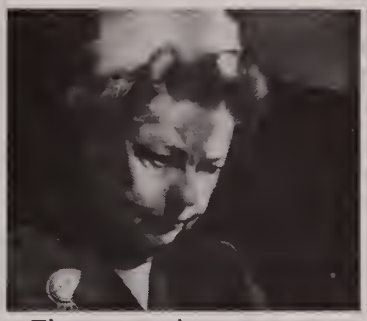
The surgical patie



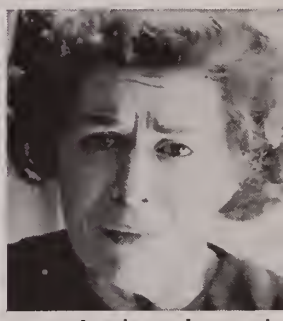
girl with dermatosis



Tension headache



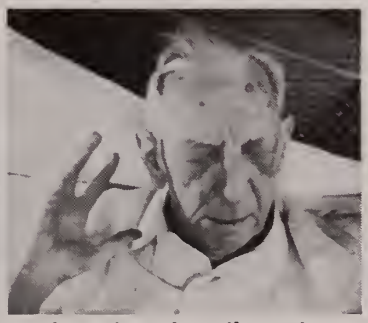
The woman in menopause



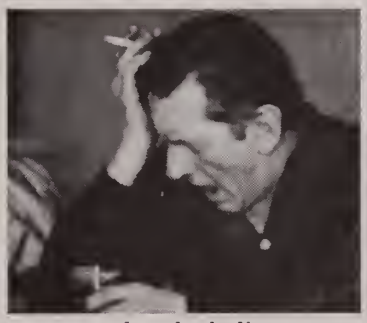
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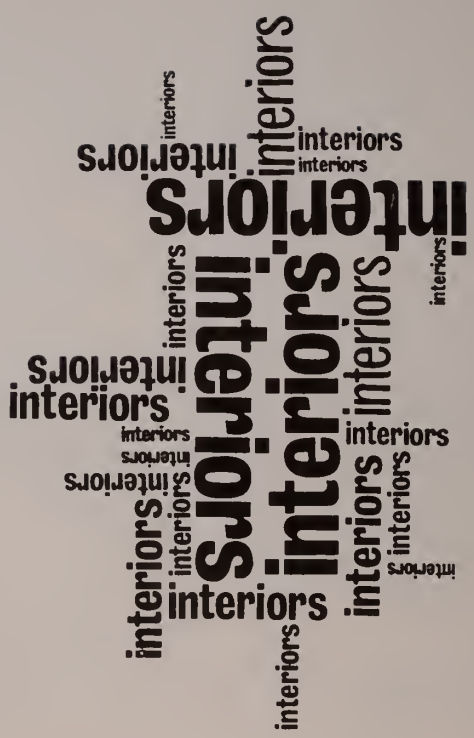
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* AMA Council on Foods and Nutrition: The Regulation of Dietary Fat, *JAMA* 181:411-423 (August 4, 1962).
AMA Council on Foods and Nutrition: Composition of Certain Margarines, *JAMA* 179:719 (March 3, 1962).



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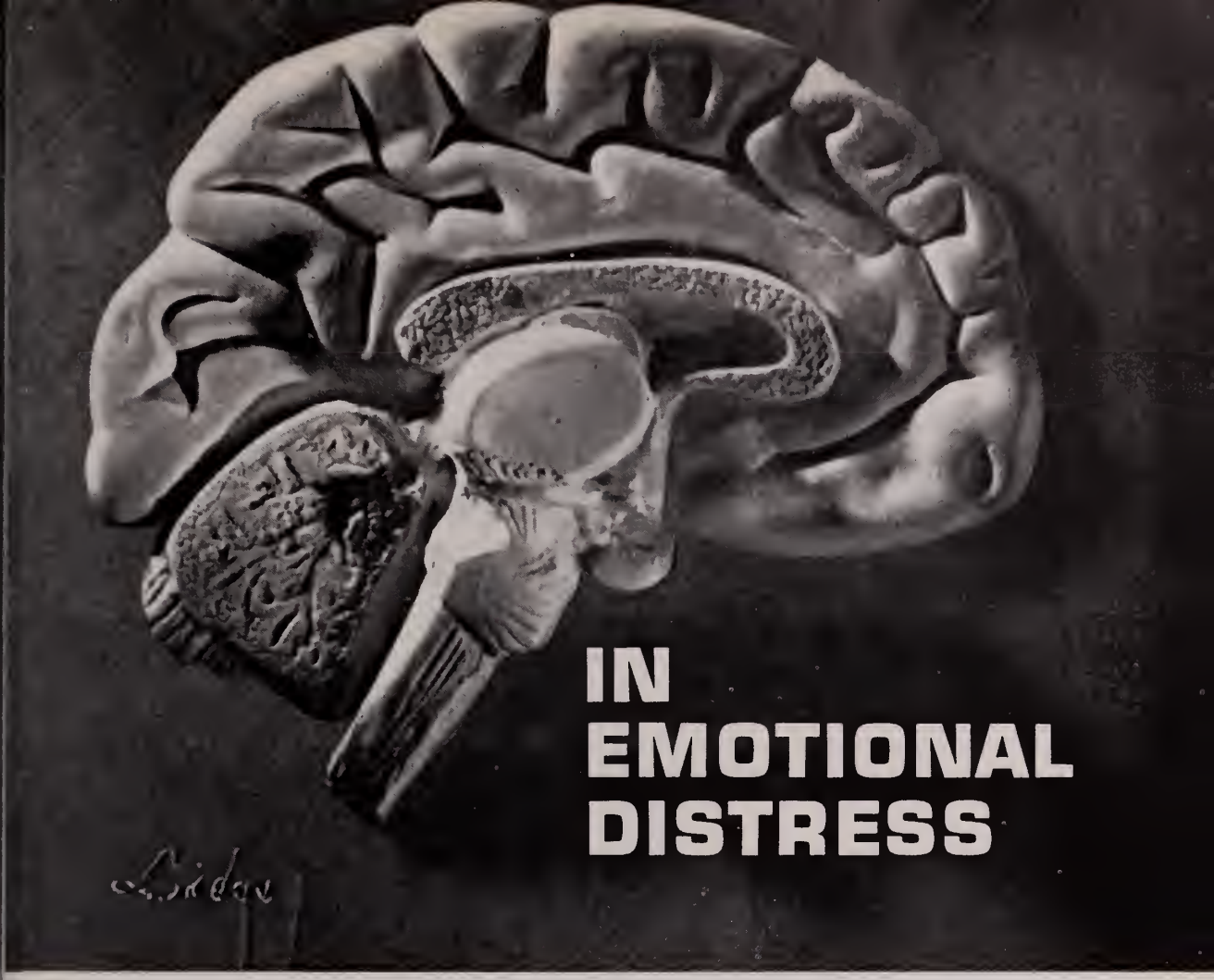
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[1] Simon, F. & Bernstein, A.: "The Treatment of Obesity in Patients with Cardiovascular Disease." Angiology, *12*:32-37, Jan. 1961.
[2] Plotz, M.: Modern Management of Obesity, J.A.M.A. *170*:1513-1515 (July 25) 1959.
[3] Bernstein, A. & Simon, F.: "Treatment of Obese Diabetics and Arteriosclerotics," Clin. Med. 907-920, May 1961.

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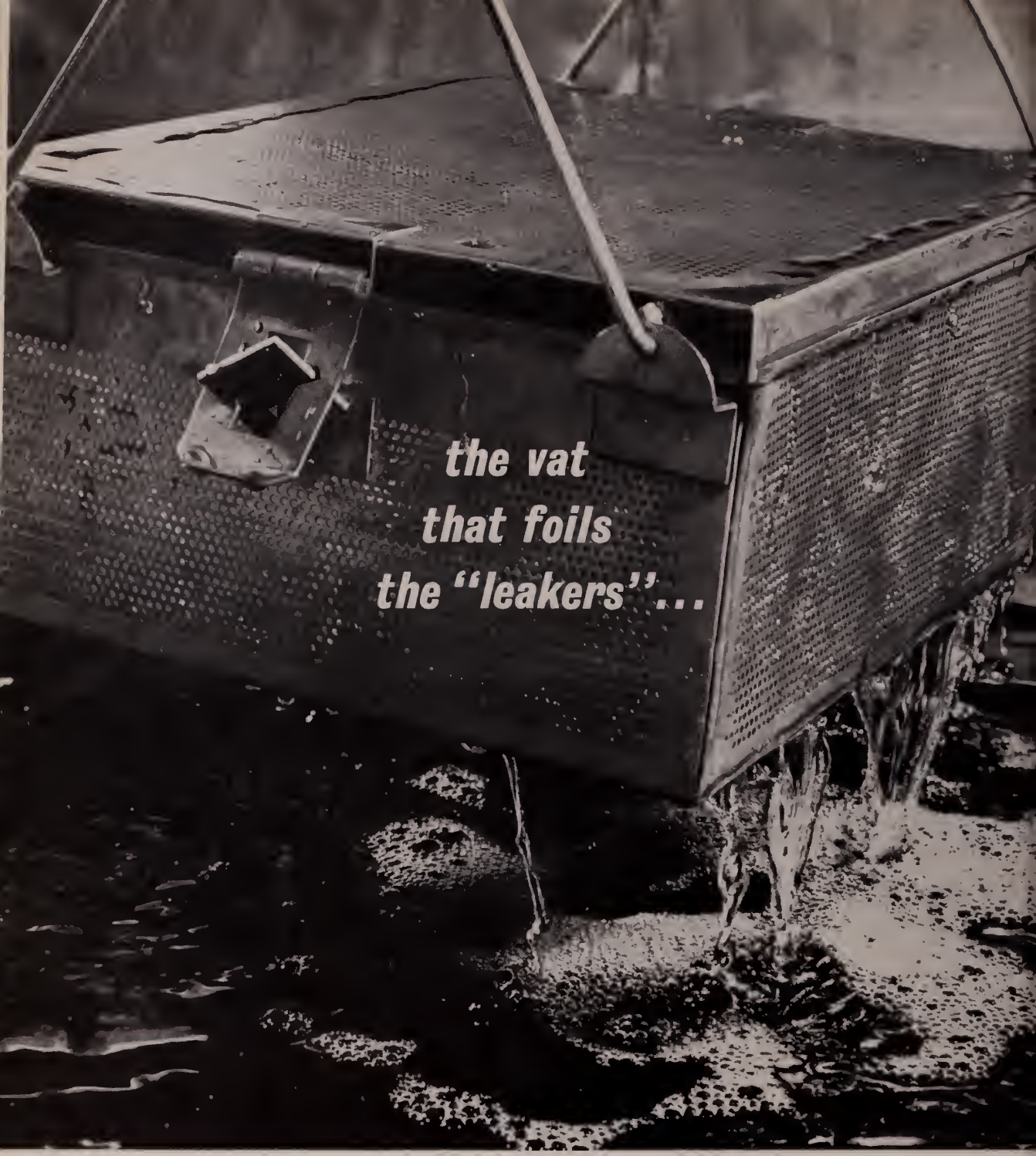
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EDITORIALS

Too Many Meetings, But–

It is understandable that many doctors are now throwing up their hands and saying: "Too many meetings." A busy specialist can be on the staffs of three hospitals, and must (to preserve each hospital's accreditation) attend a staff meeting a month. If he goes to his County Society, his Academy, and one specialty society meeting, that would make six meetings every four weeks. No wonder that so many societies are finding at their meetings more empty seats than occupied ones!

But the State meeting is something special. In the first place, it is only once a year. Then, too, it it held in the spring, and is an antidote to (or maybe an accelerator of) spring fever. Then, it is held in Atlantic City, to which people flock from all over the world for rest, relaxation, edification, and salt water taffy. If they come from California and Canada to attend meetings in Atlantic City, why should New Jersey people stay away? Again, it offers a chance to meet classmates and old friends. It enables you to participate as a voter (if you're a Delegate) or as an observer in the State's only parliament of medicine—the House of Delegates. Also, you get a wonderful postgraduate course in medicine, neatly packaged and attractively served. And by visiting the exhibits, you find out what's new in your profession so you keep right in step.

If there is any reason for *not* going to Atlantic City during the week beginning May 17, it is too obscure for notice.

The Nursing School Controversy

A controversy seems to be raging in the field of nursing education: the diploma (hospital) school versus the degree (university) school. Supporters of the latter point out that nursing is a profession; and that a true profession requires a college education. They suggest that the traditional hospital (diploma-granting) training program is actually a sort of vocational apprenticeship.

Far be it from us (or from any physician) to get into the cross-fire between these two groups of competent and articulate nursing educators. Most of us doctors are inclined to support the continuance of (if not the predominance of) the hospital-diploma type of training we knew during our internships. This is particularly true of those who interned before World War II. Our university-oriented nursing friends, however, say that this is simply a kind of sentimental fancy, a feeling of comfort in old friends and old ways, quite out of tune with these modern times. Perhaps they are right. Still, we doctors read with interest a defense of diploma schools in a recent resolution released by the trustees of the American Hospital Association and published a few months ago in their journal. Thus, they say that:

"Any program of national planning for nursing services must recognize the fact that graduates from hospital schools are, and for the foreseeable future will be, the primary source of professional nurses." The American Hospital Association also reiterated its support for all types of nursing education, collegiate, associate degree, and diploma schools. The Association added that the great damage would be done if the diploma or hospital school of nursing were downgraded in planning for the nursing future.

"The Hospital School of Nursing," they went on to say, "is *the* center for nursing education and the major source of registered nurses in the United States. It will continue to be so for a long time to come. Last year, 78 per cent of all

nursing students completing training did so in hospital schools of nursing. More than 85 per cent of the registered nurses now rendering nursing services to the United States public are graduates of diploma schools.

"Graduates of hospital schools have shown their professional competence in performing both technical nursing duties and in carrying out administrative assignments. They have kept pace with new developments in nursing and with trends in medical practice that affect nursing practice. They keep up to date with important advances in allied health fields. They have shown themselves fully competent to perform effectively and efficiently in the changing and growing field of health care. They have demonstrated ability to extend their professional skills more widely, thus rendering better nursing care to more patients.

"An adequate supply of professional nurses, both now and in the future, is absolutely essential to proper patient care. Since hospitals—the largest employer of registered nurses—depend in very large measure on diploma schools of nursing to meet their needs for professional nurses, the diploma school of nursing must be strengthened and expanded."

Many doctors have commented that college graduates who enter nursing rarely want to work at the bedside. Some of them do; but most seek managerial, teaching, research, or administrative posts. If diploma schools were abolished, bedside nursing would have to drop to nonprofessional levels—to services by aides, practical nurses, and attendants. To most physicians this would not look like a desirable change.

So without involving ourselves in this battle, we feel compelled to say that there is need for nurses at all levels. Nursing is, after all, medicine's oldest ally; and we would not want to see it torn by intraprofessional disputes.

Labelling the Prescription Bottle

The AMA Council on Drugs says that ". . . in most cases, the physician will want to tell the patient the name of the drug and to have its name and strength indicated on the label".* This is justified for the following reasons: that it is "one more step towards bringing about better understanding between patient and physician;" that if the patient has untoward reactions to the drugs, he can be handled more swiftly and effectively by a strange doctor who can read the name of the drug from the label; that it will make life easier for a new physician when the patient changes doctors; that the label "may save precious minutes and spell the difference between life and death in suicidal or accidental overdosage;" and that the label will prevent mixup when the family medicine chest contains two or more medications.

All of these reasons are scientifically sound, and it is hard to quarrel with science. Still, one can't help but lament for the days when the patient's faith in the doctor's wisdom was an ingredient in his recovery. This faith might have been shattered if the illegible prescription became converted into a merchandise order. One thinks, too, of the danger of self-medication and neighbor-medication; of the patient who does comparison shopping on prices and upbraids the corner pharmacist for what he thinks is overcharging. And, let's face it, there simply *are* some situations where what you don't know won't hurt you. Finally, there is the real danger of overdependence on medication as reflected in the rising tide of barbiturate addiction and habituation to tranquilizers.

Because the patient's own personality is a major determinant here, the Council's final suggestion is perhaps the best one. The Council concludes that: "It favors labelling of prescriptions as a general practice; but recommends that Rx pads contain boxes for a 'yes' and a 'no,' instructing the pharmacist as to whether to label." This would leave final decision where it belongs: with the responsible practitioner.

*Journal of The American Medical Association, 185: 235 (July 27, 1963)

198th Annual Meeting
The Medical Society of New Jersey

Saturday-Wednesday, May 16-20, 1964

HADDON HALL, ATLANTIC CITY, N. J.

Daily Schedule

Friday, May 15, 1964

5:00 p.m.—Board of Trustees

Saturday, May 16, 1964

10:00 a.m.—Registration Opens
10:00 a.m.—New Jersey Trauma Committee
2:00 p.m.—House of Delegates
3:30 p.m.—Golden Merit Award Ceremony
4:00 p.m.—Reception for Golden Merit Award Recipients and Their Families
4:00 p.m.—Open Discussion on Medical-Surgical Plan
6:00 p.m.—Board of Trustees' Dinner (by invitation only)
8:30 p.m.—Nominating Committee

Sunday, May 17, 1964

11:00 a.m.—Reference Committees
2:00 p.m.—House of Delegates (election)
5:30 p.m.—Reception Honoring President-Elect Calvin

Monday, May 18, 1964

9:00 a.m.—Exhibits Open
Scientific Sessions:
9:15 a.m.—Clinical Pathology, Obstetrics and Gynecology
9:30 a.m.—Pediatrics, Urology
10:00 a.m.—Medicine, Metabolism
10:00 a.m.—Motion Picture Theatre
1:00 p.m.—Luncheon and Meeting, New Jersey Association of School Physicians
2:00 p.m.—Scientific Sessions:
Allergy, General Practice
Orthopedic Surgery
Surgery
2:00 p.m.—Motion Picture Theatre
3:30 p.m.—Special Program on "Medicine and Religion"
7:00 p.m.—Annual Dinner-Dance

Tuesday, May 19, 1964

9:00 a.m.—House of Delegates
9:30 a.m.—Special Scientific Sessions:
Alcoholism
Disaster Medical Care
9:45 a.m.—Motion Picture Theatre
1:30 p.m.—House of Delegates Reconvenes
2:00 p.m.—Special Scientific Sessions:
Diabetes Mellitus
Gastric Carcinoma
2:00 p.m.—Motion Picture Theatre
6:00 p.m.—Reception-Buffet for Technical Exhibitors (by invitation only)
9:00 p.m.—Dance

Wednesday, May 20, 1964

9:00 a.m.—Board of Trustees
9:30 a.m.—Scientific Sessions:
Dermatology
Gastroenterology and Proctology, Otolaryngology, Radiology
Rheumatism
9:45 a.m.—Motion Picture Theatre
1:00 p.m.—Luncheon — New Jersey Chapters, American College of Cardiologists and American College of Chest Physicians
1:00 p.m.—Luncheon and Meeting, Radiological Society of New Jersey
2:00 p.m.—Scientific Sessions:
Anesthesiology, Cardiovascular Diseases, Chest Diseases
Ophthalmology
Psychiatry and Neurology
3:00 p.m.—Exhibits and Registration Close

House of Delegates

President, Jerome G. Kaufman, M.D., Maplewood
Secretary, Marcus H. Greifinger, M.D., Newark
Parliamentarian, Robert M. Backes, Trenton

Sessions

Saturday Afternoon, May 16, 1964

2:00 p.m.—First Session:
- Invocation
- Call to Order
- Organization of the House
- Transactions of 1963 Annual Meeting
- Introduction of Guests and Delegates from Other States
- Annual and Supplemental Reports
- Resolutions
- Proposed Amendments to the Constitution and Bylaws
- New Business
- Announcements

Sunday Afternoon, May 17, 1964

2:00 p.m.—Second Session:
- Report of Nominating Committee
- Election

Tuesday Morning, May 19, 1964

9:00 a.m.—Third Session:
- Reports of Reference Committees

11:30 a.m.—Luncheon Recess

1:30 p.m.—Third Session Continued:
- Reports of Reference Committees
- Unfinished Business
- Address of the President
- Installation of the Incoming President
- Inaugural Address
- Adjournment

The Committee on Credentials will meet at the Registration Desk each morning of the meeting.

Dinner-Dance

Monday Evening, May 18, 1964

7:00 p.m.

Honoring
PRESIDENT AND MRS. JEROME G. KAUFMAN

Welcome
- Mrs. Walter S. Booth, President, Woman's Auxiliary

Introductions
- Mrs. Philip J. Kunderman, President-Elect, Woman's Auxiliary
- Charles H. Calvin, M.D., President-Elect

Presentations

Fellow's Key
- To: Jerome G. Kaufman, M.D., President
- By: Louis S. Wegryn, M.D., Immediate Past-President

Fellowette's Pin
- To: Mrs. Walter S. Booth, President, Woman's Auxiliary
- By: Jerome G. Kaufman, M.D., President

Guest Speaker
- Honorable Joseph Weintraub, Chief Justice, New Jersey Supreme Court

Guest Artist
- Heidi Krall, Metropolitan Opera Soprano

Dancing
- Erwin Kent and His Orchestra

Reference Committees

Sunday, May 17, 1964

11:00 a.m.

Reference Committee on Constitution and Bylaws

Report of the:

- Committee on Revision of Constitution and Bylaws

Amendments to Constitution

Amendments to Bylaws

Reference Committee "A"

Reports of the:

- President
- Board of Trustees
- Secretary
- Judicial Council
- Committee on Credentials
- Executive Director

Reference Committee "B"

Reports of the:

- Treasurer
- Committee on Finance and Budget
- Committee on Publication
- Committee on Medical Student Loan Fund

Reference Committee "C"

Reports of the:

- Medical Service Administration
- Medical-Surgical Plan
- Medicare Program

Reference Committee "D"

Reports of the:

- Committee on Medical Defense and Insurance
- Committee on Medical Education
- Committee on Retirement Plan for Physicians

Reference Committee "E"

Reports of the:

- Council on Legislation
- Council on Public Relations

Reference Committee "F"

Reports of the:

- Council on Medical Services, and its Special Committees on:
  - Occupational Health
  - Workmen's Compensation

Reference Committee "G"

Reports of the:

- Council on Public Health, and its Special Committees on:
  - Cancer Control
  - Child Health
  - Chronically Ill and the Aging
  - Conservation of Hearing and Speech
  - Conservation of Vision
  - Maternal and Infant Welfare
  - Mental Health
  - Rehabilitation

Reference Committee "H"

Reports of the:

- Committee on Annual Meeting, and its Subcommittees on:
  - Scientific Exhibits
  - Scientific Program
- Committee on Honorary Membership
- Committee on Disaster Medical Care
- Committee on Nursing Education and Recruitment
- Committee on Traffic Safety
- Advisory Committee to the Woman's Auxiliary

Nominations for Emeritus Membership

Motion Picture Theatre

Monday, Tuesday, and Wednesday Mornings

Monday and Tuesday Afternoons

May 18, 19, and 20, 1964

9:45 a.m.

Aldosterone and Its Control in Edema

Produced by G. D. Searle & Co.

Aldosterone, a recently discovered hormone, is produced by the adrenal cortex and, in the normal individual, is a principal factor in the maintenance of sodium, potassium, and water balance. However, in some abnormal conditions an excess of aldosterone is produced which may result in excess sodium and water retention (edema or ascites) and in excess potassium excretion. Such increased secretion of aldosterone has been demonstrated in congestive heart failure, hepatic cirrhosis, nephrosis, and idiopathic edema.

This film reviews the normal physiology of the kidney, the influences which result in sodium retention edema or ascites, and the pharmacology of the thiazide and mercurial diuretics. In addition, it provides new information regarding the production and action of aldosterone in edematous states and the pharmacology of an aldosterone-blocking agent.

10:15 a.m.

Ligation of the Internal Iliac (Hypogastric) Arteries

Walter J. Reich, M.D., and Mitchell J. Nechtow, M.D., Chicago, Ill.

The purpose of this film is to focus the attention of those who perform pelvic and obstetric operations on the fact that serious hemorrhages are still among the principal causes of death in the United States. Pathologic conditions often arise in gynecologic and obstetric practice which cause and create a life-threatening hemorrhage. This hemorrhage is often difficult or impossible to control by packing, suturing, or both. It is in these desperate situations that ligation of the hypogastric arteries will often save a life.

The anatomic environment is not difficult to cope with, and the technic is rather simple. We have not seen a single instance of any ill effects upon the pelvic viscera, including the bladder and the bowel. The collateral circulation, in our experience, is adequate.

In our opinion, therefore, everyone engaged in pelvic surgery and operative obstetrics should become acquainted with the location of the hypogastric arteries, learn to avoid the ureter, and carry out the simple technic of ligation as rapidly and effectively as possible.

10:45 a.m.

Life in Your Hands

Sponsored by Smith Kline & French Laboratories as a Public Service.

Illustrates how heart-lung resuscitation, together with direct breathing, can maintain circulation of air and blood following a heart attack.

11:05 a.m.

Cerebral Vascular Disease— The Challenge of Diagnosis

American Heart Association

Using live action and animated diagrams, the film presents three case histories which illustrate the different features of thrombosis, hemorrhage, and focal ischemia. It demonstrates the need for a systematic clinical investigation, including tests, such as ophthalmoscopy, spinal taps, and x-ray visualization of the cerebral arteries.

2:00 p.m.

Alcoholism—The Revolving Door

Produced by Smith Kline & French Laboratories in cooperation with the American Medical Association.

Emphasizing that this report is not a warning against drinking per se, but rather a review of medicine's answer to the problem of alcoholism, a brief opening scene in a famous New York bar reveals a "small sampling of the 65 million people in the nation who drink alcoholic beverages." The plight of the degenerated chronic alcoholic is shown in a first-hand view of his surroundings in Skid Row and in his inevitable appearance the "morning after" before a magistrate's court. Switching to Hartford, Connecticut, the cameras are focused on the Blue Hills Clinic and Dudley Porter Miller, Ph.D., Director of the Connecticut Commission on Alcoholism. Cameramen and sound technicians, waiting at the Clinic, filmed unrehearsed scenes of an actual chronic alcoholic entering for treatment. Dr. Miller describes all steps in this treatment from the first moment of the patient's admission: the degree of alcoholism is determined; routine laboratory tests are made; tranquilizing drugs are administered; physical rehabilitation begins; and, finally, psycho-

logical treatment is started. An actual meeting of an Alcoholics Anonymous group is witnessed. Recovered patients describe some of the phases of the chronic illness. Dr. Marvin Block, Chairman of the American Medical Association's Committee on Alcoholism, interviews patients who had been given drug therapy to keep them from drinking and to help maintain their recovery. Finally, a group therapy meeting in action is covered.

2:35 p.m.

The One Who Heals

Produced by the Department of Medicine and Religion, American Medical Association.

Features a series of vignettes that illustrate the kind of situations in which the physician and the clergy are both involved in the care of patients. Each story indicates that faith is a factor in the treatment of the patient or in dealing with the patient's family. Solutions to the problems presented are not given; rather, the situations encourage discussion as to how the physician and clergy could effectively work together. The religious faith of the individual patient is a vital factor in his total health.

3:10 p.m.

Town Against TB

Presented by the New Jersey State Department of Health with the assistance of Lederle Laboratories.

Details the working partnership between medical society, health department, and voluntary health agency which is required to initiate a community testing program. The film provides a step-by-step record of the Toms River TB testing program from inception to conclusion. The result is a blueprint which can be applied by medical, health, and civic leadership audiences toward the planning of disease detection and immunization programs in all communities.

Film program arranged and presented through the cooperation of Smith Kline & French Laboratories, Philadelphia, Pa.

Medicine and Religion

Special Program

Monday Afternoon, May 18, 1964

3:30 p.m.

"Man is physical, spiritual, mental, and social. He is a whole being, and in ill health, he requires total care and treatment." (AMA Department of Medicine and Religion)

Representative denominational clergymen have been invited to participate in this special program which will be moderated by the Rev. Dr. Paul B. McCleave, Director of the AMA's new Department of Medicine and Religion.

In connection with this program, the AMA film, "The One Who Heals," will be shown in the motion picture theatre. The film features a series of vignettes that illustrate the kind of situations in which the physician and the clergy are both involved in the care of the patient.

Golden Merit Award Ceremony

Saturday Afternoon, May 16, 1964

3:30 p.m.

The Golden Merit Award, established in 1957, is conferred upon every member of The Medical Society of New Jersey who has held the degree of Doctor of Medicine for fifty years.

Presiding

Jerome G. Kaufman, M.D., President

Master of Ceremonies

John F. Kustrup, M.D., Chairman, Council on Public Relations

Marshals

Presidents of component societies whose members are receiving awards.

4:00 p.m.

Reception for Award Recipients and Their Families

Scientific Sessions

Monday Morning, May 18, 1964

CLINICAL PATHOLOGY, OBSTETRICS AND GYNECOLOGY

Joint Session

Clinical Pathology

PAUL STEINLAUF, M.D., Chairman, Paterson
RAYMOND E. CONOVER, M.D., Secretary, Belmar

Obstetrics and Gynecology

DANIEL B. ROTH, M.D., Chairman, Teaneck
EUGENE J. SLOWINSKI, M.D., Secretary, Newark

9:15 a.m.

Election of Officers

9:30 a.m.

Symposium—Early Diagnosis of Leisons of the Breast

Moderator

Daniel B. Roth, M.D., Teaneck; Attending in Obstetrics, Englewood Hospital

Clinical Considerations

Hugh Auchincloss, M.D., Ridgewood; Assistant Clinical Professor of Surgery, Columbia University College of Physicians and Surgeons; Associate Attending in Surgery, Presbyterian Hospital, New York, N. Y.

Mammography—With Associated Comments on Correlation With Thermography

Simon M. Berger, M.D. Chief of Diagnostic Radiology, Albert Einstein Medical Center, Philadelphia, Pa.

Mammography, the roentgen evaluation of the breast, has had a resurgence of popularity. In the past 11 years, it has been employed in over 20,000 patient examinations at the Albert Einstein Medical Center—Northern Divisions, Philadelphia.

At its best, it can identify non-palpable intraductal carcinoma due to a characteristic calcific deposition that can be visualized radiographically.

Frequently it helps in evaluating the nature of an area of questionable clinical prominence, and its use generally permits one to identify and operate smaller lesions with less auxiliary involvement.

However, it cannot and must not attempt to replace surgical biopsy in the clinically dominant mass, and an appreciation of its limitations is as important as its value.

Modification of routine mammography by intraductal contrast injections, cystaspiration with double contrastair injection of cysts, and infrared emission patterns (thermography) are also employed; and their values and limitations will be discussed.

Pathology

Hugh G. Grady, M.D., Professor of Pathology, Seton Hall College of Medicine, Jersey City

Open Discussion

10:45 a.m.

Lesions of the Vulva

Mortimer D. Speiser, M.D., Clinical Professor of Obstetrics and Gynecology, New York University School of Medicine; Director of Obstetrics and Gynecology, French Hospital, New York, N. Y.

Diagnostic difficulties are encountered in those vulvar diseases characterized by a whitish appearance. Many are innocuous and frequently devoid of subjective symptoms. A few are malignant or potentially so. The group to be demonstrated includes vitiligo, neurodermatitis, lichen planus, moniliasis, lichen sclerosus et atrophicus, intraepithelial carcinoma, Bowen's disease, kraurosis, and leukoplakia. Several of these are simply genital manifestations of a more widespread skin disorder altered in appearance by the locale, thus making the diagnosis difficult. The terms kraurosis and leukoplakia need reevaluation. Biopsies are essential for an unequivocal diagnosis prior to definite therapy.

Pathology of Vulvar Leisons

Anthony L. Pietroluongo, M.D., Associate Professor of Pathology, Seton Hall College of Medicine; Director of Laboratories, Margaret Hague Maternity Hospital, Jersey City

Open Discussion

11:45 a.m.

Visit to Exhibits

MEDICINE, METABOLISM

Joint Session

Medicine

Peter H. Marvel, M.D., Chairman, Northfield
Elmer J. Elias, M.D., Secretary, Trenton

Metabolism

Werner J. Hollendonner, M.D., Chairman, Trenton

John F. Marshall, M.D., Secretary, Trenton

9:30 a.m.

Election of Officers

9:40 a.m.

Endocrine Control of Renal Function

Clarence L. Gantt, M.D., Department of Medicine, University of Illinois School of Medicine, Chicago, Ill.

The kidney is largely dependent on hormonal control for retention and excretion of water, sodium, potassium, calcium, and phosphorus. In each case there is an afferent receptor mechanism which detects changes in body composition or in the distribution of body fluids, and acts as a counter-regulatory device to increase or decrease the secretion of the hormone that affects the kidney. In some disease states these mechanisms produce quantitative changes that are detrimental to the body. Certain tumors produce substances which simulate the action of the naturally occurring hormones and produce disease states by this mechanism.

10:05 a.m.

Tumors of the Thyroid Gland—Diagnosis and Management

Joseph A. Linsk, M.D., Associate in Medicine, Atlantic City Hospital

The controversial nature of thyroid tumors will be discussed with an attempt to clarify the pathway from lump to definitive therapy, if any. The questions to be examined are:

1. Incidence of thyroid cancer.
2. Role of the pathologist.
3. Role of the clinicians.
4. Surgical versus medical therapy.
5. Which surgical approach is best?

By considering patient's age and sex, age of the nodule, physical characteristics and symptoms produced by the mass, overall thyroid function, avidity for radioactive iodine, histology (biopsy) and cytology (thin needle aspiration), it is hoped that the nodule problem will be somewhat reduced.

10:25 a.m.

The Clinical Value of a Simplified Approach to Laboratory Diagnosis of B-Complex Vitamin Deficiency

Carroll M. Leevy, M.D., Professor of Medicine, Seton Hall College of Medicine, Jersey City

Co-Author: Herman Baker, Ph.D., Jersey City

10:45 a.m.

Differential Diagnosis of Liver and Biliary Tract Disease Using Nuclear Methods

Vincent M. Whelan, M.D., Director, Department of Radiology, Riverview Hospital, Red Bank.

Co-Author: Andrew P. Dedick, M.D., Red Bank

Radioiodinated Rose Bengal used in tracer definition of hepatic cell function and biliary tract potency (hepatogram) and radioactive gold for liver scanning, yield important information in the differential diagnosis of patients with liver disease and manifesting jaundice, hepatomegaly, etc.

This presentation is based on more than two hundred and fifty patients studied during the past two years.

An analysis of the results of the simplified approach reveals diagnostic accuracy of high order when compared with other diagnostic parameters of hepatic and biliary disease.

11:05 a.m.

General Discussion

11:30 a.m.

Visit to Exhibits

PEDIATRICS, UROLOGY

Joint Session

Pediatrics

Avrum L. Katcher, M.D., Chairman, Flemington
Seymour F. Kuvin, M.D., Secretary, Morristown

Urology

Bernard M. Kramer, M.D., Chairman, Perth Amboy
Milton L. Lieberman, M.D., Secretary, Elizabeth

9:30 a.m.

Election of Officers

9:45 a.m.

Panel—Lower Urinary Tract Problems in Children

Urethral Meatal Stenosis—Oversight and Consequences

Samuel J. Arnold, M.D., Morristown; Chief of Urology, St. Clare's Hospital Denville

The strictured meatus has been significantly overlooked in the male child; seriously in the female child. The evidence for this, abundantly present in clinical material and in the literature, is submitted in detail. The consequences of such an oversight are explored and found to be always meaningful and sometimes grim. Of particular interest is the concept of a relationship between these small lesions and those large questions of stress incontinence and enuresis—a relationship which, when examined carefully, it is felt may provide some fresh insights into these troublesome problems.

Anatomy and Physiology

Robert L. Lieb, M.D., Attending in Urology, Newark City Hospital

There are a number of anatomical and physiological changes from the normal that occur in the lower urinary tract of children that give rise to vesicoureteral reflux. About one-half of these cases are associated with obstructions, such as urethral meatal stenosis, posterior urethral valves, and contracture or median bar at the bladder neck. Another one-third of the cases are bladder dysfunctions due to congenitally deficient innervation. A third small group are associated with neurogenic dysfunction on the basis of myelomeningocele, spina bifida, or spinal cord injury. Congenital mal-development of the lower ureter or ureterovesical junction is another group. The fifth group includes ectopic ureter and the surgically treated ureterocele. The abnormal effects of these various conditions involve changes in the ureter—such as length, caliber, flexibility, anchoring of the lower end, and vesical pressure.

Newer Concepts of Infection

Stuart S. Stevenson, M.D., Jersey City; Director of Pediatrics, St. Luke's Hospital, New York, N. Y.

Urinary tract infection is the second commonest in childhood, and the diagnosis must not be missed. It is a potentially *fatal* warning sign: in inadequately treated cases, the kidneys may ultimately and silently be destroyed and the mortality approaches 20%.

Adequate diagnosis requires a high degree of suspicion, the quantitative demonstration of bacteria, and their antibotic sensitivity, in the urine, and testing for obstructive uropathy. This means hospitalization for even the "mild" case—prognosis is unrelated to severity of clinical findings.

Adequate treatment requires appropriate antibiotic therapy based on knowledge that the focus of infection is in the kidney parenchyma itself, and relief of obstructive uropathy when present.

Diagnosis and Management of Urethral Obstructions

John H. McGovern, M.D., Assistant Professor of Clinical Surgery (Urology), Cornell University Medical College; Associate Attending in Surgery (Urology), The New York Hospital James Buchanan Brady Foundation, New York, N. Y.

The insidious nature of chronic pyelonephritis, its resistance to antimicrobials, its high prevalence, and its poor prognosis, make investigation of urinary tract infections in children important. The majority of such infections occuring in children are based on obstructive anomalies. This is demonstrably true of persistent or recurrent infections.

Operative correction of such anomalies has recently aroused considerable discussion. Still under debate are such matters as indications, type of operation, or even whether better therapeutic results may be achieved by avoiding any operative procedures.

The results herein reported were obtained in a surgically oriented program and are pertinent to seeking a solution of the problems that remain moot. A review of 114 children who had 161 ureters reimplanted into the bladder is given. The review is composed of two parts. The first is the status of the children at their first anniversary; the second is the long term follow-up of a 111 ureteral reimplantations in 76 children, two to eight years following operation. The average follow-up is 51 months. A detailed analysis of these cases is presented.

Conservative Management of Lower Urinary Tract Disease

Alexander J. Michie, M.D., Associate Professor of Pediatric Urology, The University of Pennsylvania School of Medicine; Senior Surgeon, Children's Hospital, Philadelphia, Pa.

With the exception of meatal stenosis, bladder infections are the most common lower urinary tract diseases in childhood. Chronic bladder infections in children frequently cause functional disturbances, such as a persistent residual urine or vesicoureteral reflux. All of these bladder function abnormalities, as well as meatal stenosis, can be corrected surgically. But in many patients the abnormal bladder function is reversible. This is especially true when the urinary infection is treated for a long time, several months, with antibacterial drugs. In our patients we administer the antibacterial therapy for three

months and then reevaluate the functional deficit. If three months of antibacterial therapy causes a functional improvement, then operative intervention is postponed for another three months. This program has greatly reduced the need for operative intervention.

11:45 a.m.

Visit to Exhibits

1:00 p.m.

Luncheon and Business Meeting—New Jersey Association of School Physicians

Reservations: Edward A. Schauer, M.D.
53 Main Street, Farmingdale

Monday Afternoon, May 18, 1964

ALLERGY, GENERAL PRACTICE

Joint Session

Allergy

ARTHUR A. GOLDFARB, M.D., Chairman, Teaneck
WILLIAM I. WEISS, M.D., Secretary, Newark

General Practice

NICHOLAS E. MARCHIONE, M.D., Chairman, Vineland
EDWARD A. SCHAUER, M.D., Secretary, Farmingdale

2:00 p.m.

Election of Officers

2:10 p.m.

Panel—Pediatric Allergy

Moderator

Arthur A. Goldfarb, M.D., Assistant Clinical Professor, Albert Einstein College of Medicine, New York, N. Y.; Chief of Allergy Service, Holy Name Hospital Teaneck

Immunology of Allergy—Incidence of Allergy —When Should the Allergist Be Consulted?

Arthur A. Goldfarb, M.D., Teaneck

A review of the incidence of allergy will reveal 18.6% of 16,575 individuals surveyed to have major allergy such as asthma, hayfever, or eczema. Over 50% of these major allergies appear in children. Of 6,036 children surveyed, 23.7% had major allergy.

A classification of immunological disease will show the basic difference between immediate skin reacting allergy and delayed skin reacting allergic disease and the theoretical basis of the treatment of allergy. The pathology of allergy and the chemical mediators of allergic disease will be reviewed.

The importance of early treatment of allergic disease in childhood, the prophylaxis of allergic disease, and the approach to treatment will be discussed. The fact that children do not "grow-out" of allergic disease will be demonstrated.

Bronchial Asthma in Infancy and Childhood—Types of Treatment

Paul F. deGara, M.D., Clinical Associate Professor, Cornell University Medical College; Associate Attending in Pediatrics and Chief of Pediatric Allergy, New York Hospital, N. Y.

After briefly discussing frequency and diagnostic features of childhood asthma, the various types of treatment will be reviewed. These include: avoidance of offending agents and replacement with harmless substitutes, if possible; specific ("hyposensitization") therapy; non-specific forms of treatment; and symptomatic therapy. The use of bronchodilators and of sympatomimetic drugs, as well as steroid therapy, their indications, and risks will be discussed.

Pollinosis in Childhood—Types of Treatment

William B. Nevius, M.D., East Orange; Attending in Pediatrics and Chairman of Allergy Section, Orange Memorial Hospital

The Chronic Allergic Child—Treatment and Prognosis

Martin Green, M.D., Assistant Professor of Pediatrics, The Jefferson Medical College of Philadelphia, Pa.; Chief Attending in Pediatrics, Atlantic City Hospital

The progress of 160 children with persistent severe asthma of at least one year's duration is reviewed. These children were all in residence in the Asthmatic Unit of the Betty Bacharach Convalescent Home. The asthmatic children are divided into etiological groups where possible, based on the history, physical examination, laboratory tests, and allergic diagnostic survey. The results of treatment with conclusions as to prognosis are presented.

Open Discussion—Questions and Answers

3:10 p.m.

Panel—Repository Treatment of Allergic Disease

Moderator

Maury D. Sanger, M.D., Brooklyn, N. Y.; Assistant Clinical Professor, Albert Einstein College of Medicine; Associate Attending in Pediatric Allergy, Bronx Municipal Hospital Center, N. Y.

Choice of Patient and Indications for the Use of Repository Therapy

Nathan Schaffer, M.D., Attending in Allergy, East Orange General Hospital

Results of Repository Therapy

Solomon Aronoff, M.D., Clinical Assistant Professor of Medicine, Seton Hall College of Medicine; Attending Physician and Chief of Allergy Clinic, Medical Center Jersey City

The author has been using Emulsions of Allergenic Extracts since 1959 in the treatment of allergic conditions. This paper will review his results and compare them with the results obtained in patients treated with Unemulsified Allergenic Extracts and also in patients who were previously treated with unemulsified extracts and subsequently treated with emulsified extracts.

Advantages and Disadvantages of Repository Therapy

Frank H. Feldman, M.D., Chief of Allergy, Newark Beth Israel Hospital

The advantages and disadvantages of repository, or emulsion, treatment in allergy will be discussed.

The advantages are these:

1. Infrequent injections for desentization.
2. Longer duration of immunity.
3. Egg sensitizations can be treated more easily.
4. Anaphylactoid Reactions are less prevelant.
5. Super-sensitive cases can be given adequate dosage.

Disadvantages:

1. Necessity for good emulsions.
2. The work necessary to prepare emulsions.
3. Necessity for re-emulsification.
4. Checking of emulsions before injections.
5. Knowledge of how to give emulsions.
6. Occurrence of nodules and mineral oil granuloma and infection.

Conclusion:

Opinion of patients who have received this treatment is favorable.

Complications of Repository Therapy

Edward E. P. Seidmon, M.D., Plainfield; Chief of Allergy, Hunterdon Medical Center, Flemington

The Present Status of Repository Therapy

Maury D. Sanger, M.D., Brooklyn, N. Y.

Open Discussion—Questions and Answers

4:20 p.m.

Visit to Exhibits

ORTHOPEDIC SURGERY

Daniel J. O'Regan, M.D., Chairman, Jersey City
Daniel M. Winters, M.D., Secretary, Red Bank

2:00 p.m.

Election of Officers

2:10 p.m.

Disability Evaluation—Its Logical Development

John L. Grow, M.D., Chief Surgical Consultant, Division of Disability Operations, Social Security Administration, United States Department of Health, Education, and Welfare, Baltimore, Md.

Disability has been noted to be the absence of "ability." Each year more and more physicians in every type of practice are being called upon to express an opinion as to whether someone may be disabled. Some sources desire only an opinion as to totality or percentage of lost ability, while others require the examining physician to submit his historical, physical, and laboratory findings on a patient without an expression of his own opinion as to whether or not disability exists.

A logical development of the concept of lost ability to work depends upon a thorough understanding by the physicians involved at all stages of the process; of the nature of medical evidence, its relation to impairment and remaining functional capacity. Fitness to work is the outcome of equating remaining capacity to job demands.

2:30 p.m.

Symposium—Fractures and Dislocations

Fractures and Dislocations of the Elbow in Children

Frederick M. Smith, M.D., Falmouth, Mass.; Consultant in Orthopedic Surgery, Cape Cod Hospital, Hyannis, Mass.

Gait Problems in Children

Robert G. Greene, M.D., Assistant Attending in Orthopedic Surgery, The Mountainside Hospital, Montclair

Review of a 10-year experience in soft tissue tumors of the hand at Mountainside Hospital, Montclair, New Jersey, reveals the more common soft tissue tumors to be ganglions, giant cell tumor of tendon sheath, inclusion cysts, and malignant tumors of the skin.

A case of metastasis of malignant lung cancer to the hand and two liposarcomas and an embryonal rhabdomyosarcoma are among the more unusual tumors noted.

Fractures and Dislocations of the Hip

Daniel M. Winters, M.D., Associate Attending in Orthopedic Surgery, Riverview Hospital, Red Bank

4:15 p.m.

Visit to Exhibits

SURGERY

James B. Cummins, M.D., Chairman, Morristown

C. Buckman Katzenbach, M.D., Secretary, Flemington

2:00 p.m.

Election of Officers

2:15 p.m.

Symposium — Vascular Problems of the Extremities

Surgical Treatment of Arteriosclerotic Occlusion Disease

William E. Philip, M.D., Cardiovascular Surgery, Morristown

1. Abdominal Aorta
   (1) Aneurysm — Resection
   (2) Obliterative Disease
      A. Diffuse — Resection and grafting
      B. Localized — Endarterectory and/or patching.
   (3) Aortography
      A. Necessary for diagnosis.
      B. Technic
      C. Relative safety with new contrast media.
   (4) Results of surgery — Generally good — dependent on run-off of distal arterial tree for both aneurysm and obliterative disease. (Review of operated cases with follow-up)

2. Femoral Disease
   (1) Definition — Ischemia lower extremities with palpabal femoral pulses.
   (2) Diagnosis — General terms — pulses, color, temperature to touch, tissue necrosis.

3. Localization — Femoral arteriography — technic.

4. Selection of surgical candidates.
   (1) Indicated in the face of amputation if arteriography renders restoration of flow possible unless otherwise contraindicated.
   (2) Elective — Age, occupation, temperament.

5. Surgical Technics
   (1) Lumbar Sympathectomy — if no popliteal result is evident.
   (2) Endarterectomy — Limited application (patch graft).
   (3) Vein by-pass—limited.
      A. Advantages
         a. Higher percentage of long term patency.
         b. No foreign body.
      B. Disadvantages
         a. Limited length of vein.
         b. Prolongation of operative time.
   (4) Prosthetic By-Pass.
      A. Advantages
         a. Adequate length (common femoral to popliteal).
         b. Availability.
         c. Shortened operative time in poor risk patient. Fewer collaterals disturbed.
      B. Disadvantages
         a. Loses some pliability with time.
         b. Requires neo-intima.
         c. Late obstruction.

6. Details of Technic
   (1) Adequate proximal pressure.
   (2) Circumvention of disease — often common femoral to popliteal.
   (3) Use of prosthetic graft — Teflon.

7. Results.
   Tabulation of operated cases with follow-up.

Medical Indications for Surgery on Arteriosclerotic Occlusive Disease

Gustave Suffness, M.D., Attending in Peripheral Vascular Diseases, Alexian Brothers Hospital, Elizabeth

Careful selection of patients is necessary when evaluating those who will benefit from peripheral arterial surgery. We are usually concerned with the geriatric group with widespread vascular involvement, and most of these will do satisfactorily under the proper medical regime. Surgery does have a very positive place in the treatment, and the indications are most often clean-cut.

A complete history and physical examination—listing age, work habits, general physical activities and potentialities—are valuable in determining treatment. Detailed examination of the vascular tree must be performed, and this should be correlated with a cooperative and a knowing radiologic service for the purpose of urgiographic studies.

Finally, the vascular surgeon must have enough experience and interest to handle the problem of the arterial insufficiency.

Experimental as Well as Practical Surgery in the Treatment of Arteriosclerotic Occlusion Disease

Joseph J. Timmes, M.D., Professor of Surgery, Seton Hall College of Medicine, Jersey City

Chronic major vascular occlusions due to arteriosclerosis remain a problem which has only been partially resolved by surgical measures. In the past few years, we have been disappointed with the use of the synthetic graft in the femoral area. Today it appears that we may have to abandon the prosthesis to a certain degree in the lower extremity and substitute endarterectomy with a venous onlay graft. In general, vascular surgeons are most conservative in this problem because of the discouragingly poor late results.

Methods used in endarterectomy and the set of instruments which can be made locally in any hospital will be demonstrated. Reference to animal experimental work will also be included.

Sympathectomy, which was rather widely used several years ago and then used less frequently in the past few years, is now again proving to be a useful tool in the treatment of chronic vascular occlusions in selected cases. It is particularly valuable in the patient with a "wet" foot. It does protect the skin, and this is the key to the onset of gangrene. However, it is still true that patients must stop smoking if sympathectomy is to be of value.

In the upper extremity, arm claudication is rare but does occur. Most of the cases seen by us today are in patients who have had cardiac catheterizations through the brachial artery and as a result have thrombosis in some section of the brachial artery.

4:15 p.m.

Visit to Exhibits

Tuesday Morning, May 19, 1964

ALCOHOLISM

A special scientific session arranged and presented in cooperation with the New Jersey State Department of Health.

9:30 a.m.

Panel—The Identification and Treatment of the Alcoholic

Moderator

V. Terrell Davis, M.D., Director, Division of Mental Health and Hospitals, New Jersey State Department of Institutions and Agencies, Trenton.

Identification of the Alcoholic

Selden D. Bacon, Ph.D., Director, Center of Alcoholic Studies, Rutgers—The State University, New Brunswick

Treatment of the Acute Alcoholic

David I. Canavan, M.D., Franklin Lakes; Medical Director, Mount Carmel Hospital for Alcoholics, Paterson

Treatment of the Chronic Alcoholic

Paul C. Fagan, M.D., Bloomfield; Medical Director, Alcoholism Treatment Center, The Mountainside Hospital, Montclair

11:30 a.m.

Visit to Exhibits

DISASTER MEDICAL CARE

A special scientific session arranged and presented in cooperation with the Society's Committee on Disaster Medical Care

9:30 a.m.

Symposium — Emergency Preparedness and the Physician

The Role of the Division of Health Mobilization in Civil Defense and Emergency Health Preparedness

Gabriel P. Ferrazzano, M.D., Chief, Division of Health Mobilization, Office of the Surgeon General, Public Health Service, United States Department of Health, Education and Welfare, Washington, D. C.

The Public Health Service has responsibility for preparing national emergency health and medical plans, and developing preparedness programs to achieve a state of health services' readiness to meet all conditions of a national emergency.

The program direction and service coordination of emergency mobilization activities are centered in the Division of Health Mobilization, Office of the Surgeon General.

Civil Defense and Medicine

Col. Louis J. Hackett, Jr., M.D., MC, USA, McLean, Va.; Medical Advisor, Office of Civil Defense, United States Department of Defense, Washington, D. C.

An up-to-the-minute report of the activities of the Office of Civil Defense, Department of Defense—with emphasis on current program objectives and the role of the medical profession in attaining civil defense goals.

Disaster and the AMA in 1964

Francis C. Jackson, M.D., Pittsburgh, Pa.; Chairman, Committee on Disaster Medical Care, American Medical Association, Chicago, Ill.

The Committee on Disaster Medical Care of the American Medical Association is embarking on a new program designed to provide physicians with a more precise prospective of their role in Disaster Medical Care. (Joint action by professional socicties in particular will be emphasized.) It is planned that natural disasters scientifically surveyed and studied by a proposed Disaster Survey Center will be outlined. In addition, the design of a new handbook on Disaster Medical Care will be reviewed. The results of recent consultant services to the various Commissions and Committees on Disaster Medical Care of other state societies will be summarized. A new proposal to develop Interstate Disaster Councils currently under advisement will be presented. The program of the first annual National Conference on Disaster Medical Care will be summarized.

Discussion From State Level

Roscoe P. Kandle, M.D., Commissioner, New Jersey State Department of Health, Trenton

Question and Answer Period

11:30 a.m.

Visit to Exhibits

GASTRIC CARCINOMA

A special scientific session arranged and presented in cooperation with The Academy of Medicine of New Jersey and the New Jersey State Department of Health

2:00 p.m.

Panel—Advances in the Diagnosis and Treatment of Carcinoma of the Stomach

Advances in Direct Observation of Malignant and Premalignant Lesions of the Stomach—Fiberoscopy and Cinefiberoscopy

Victor W. Groisser, M.D., Associate Professor of Medicine and Associate Director of Division of Gastroenterology, Seton Hall College of Medicine, Jersey City; Assistant Attending Physician, The Mountainside Hospital, Montclair

Movies of intragastric lesions may now be taken using the glass fibergastroscope. This flexible instrument with 100,000-200,000 glass fibers is easily passed and permits prolonged observation of the stomach, including heretofore inaccessible areas such as the distal antrum and prepyloric area. The fiberscope adds another important dimension to our diagnostic efforts. In addition, the ability to take movies provides an objective record which may be studied at length and compared to other diagnostic information. Movics have becn taken of a wide variety of lesions including sarcomas, lymphomas, adenomas, and carcinomas as well as ulcers, erosions, gastric atrophy, and a wide variety of bleeding lesions.

The technic of cinefiberscopy will be demonstrated, and representative movies of gastric lesions will be shown.

Exfoliative Cytology in the Diagnosis of Gastric Carcinoma—Special Reference to Gastric Ulcer

Kendrick P. Lance, M.D., Assistant Clinical Professor of Medicine, Seton Hall College of Medicine, Jersey City; Director of Medicine and Director of Medical Education, St. Joseph's Hospital, Paterson

Over 300 patients have undergone gastric lavage for cytologic study in our laboratory. One third of this group was studied because of the x-ray diagnosis of gastric ulceration, either alone or in combination with other lesions. Approximately one-tenth had ulcers of questionable nature, and seven-tenths had either benign ulcers, or ulcers not characterized as benign or malignant by the radiologist.

This study presents cytologic, endoscopic, radiologic, and follow-up data on this group. It is concluded that cytology is a valuable adjunct in the delineation and management of gastric ulcers.

The Role of Chemotherapeutic Agents in the Management of Gastric Malignancy

Bernard J. Koven, M.D., Assistant Professor of Medicine and Director of Division of Oncology, Seton Hall College of Medicine, Jersey City; Assistant Chief of Diagnostic Service, Memorial Sloan-Kettering Cancer Center, New York, N. Y.

Carcinoma of the stomach is refractory to treatment with chemotherapy utilizing alkylating agents, such as nitrogen mustard and its newer analogs. However, some objective benefit may be produced with the drug 5-Fluorouracil in about twenty percent of selected cases. Since toxicity may be severe, the physician must be familiar with the clinical and laboratory abnormalities which this agent may produce in order to avoid irreversible toxic effects. Further modifications of dosage schedules may improve the therapeutic ratio for this agent.

The Present Role of Surgery in the Treatment of Gastric Carcinoma

John J. Knightly, M.D., Assistant Professor of Surgery, Seton Hall College of Medicine;

Assistant Attending in Surgery and Chairman of Tumor Board and Registry, Medical Center, Jersey City

Panel Discussion

Moderator

Victor W. Groisser, M.D., Montclair

4:00 p.m.

Visit to Exhibits

Tuesday Afternoon, May 19, 1964

DIABETES MELLITUS

A special scientific session arranged and presented in cooperation with The Academy of Medicine of New Jersey and the New Jersey Diabetes Association.

2:00 p.m.

Symposium — Oral Hypoglycemic Agents

Mechanisms of Action

LeRoy A. Peseh, M.D., Associate Professor of Medicine, Rutgers University Medical School, New Brunswick

Since the introduction of oral hypoglycemic agents into clinical use in 1955, there has been extensive investigation carried out concerning the comparative pharmacology of these compounds together with the accumulation of considerable information concerning their mode and site of action. However, the elucidation of specific mechanisms whereby these drugs alter metabolism in the diabetic state and regulate glucose homeostasis has been extremely difficult. Through the extensive clinical use of these compounds, new information has come to light concerning the more fundamental problems of diabetes and the action of insulin. These various aspects of the mechanisms of action of the oral hypoglycemic agents will be discussed.

Clinical Usage

Charles R. Shuman, M.D., Clinical Professor of Medicine, Temple University School of Medicine, Philadelphia, Pa.

Since 1955, oral antidiabetic agents have been used in the treatment of the diet-refractory adult patient. They have been effective in those with mild or moderate diabetes of recent onset and with low insulin requirements, although there are numerous exceptions. These drugs are indicated for use in situations where control of blood glucose cannot be achieved by dietary means in patients who are not insulin-dependent. The drugs available for clinical use at present are the following:

Sulfonylureas:

1. Tolbutamide - Orinase (Upjohn)
2. Chlorpropamide - Diabinese (Pfizer)
3. Acetohexamide - Dymelor (Lilly)

Biquanide:

1. Phenformin - DBI (U. S. Vitamin)

The successful use of these compounds requires careful diet planning. Many secondary or delayed failures in treatment with oral agents have occurred in those patients who do not maintain a satisfactory dietary program. In the unstable diabetic patient, DBI has been employed in combination with sulfonylurea drugs or with insulin to improve control of the disease. Methods for the use of these drugs and their role in diabetic management will be presented.

Toxicity

Martin G. Goldner, M.D., Professor of Medicine, State University of New York, Downstate Medical Center, College of Medicine; Director of Medicine, Jewish Hospital, Brooklyn, N. Y.

The undesirable or toxic side effects of the oral hypoglycemic agents will be discussed under the following three headings:

1. Hypersensitivity reactions or symptomatic incompatibility.
2. Exaggeration of the desirable hypoglycemic effect by intrinsic and extrinsic factors; i. e., decreased excretion or metabolism of the drugs or potentiation by other drugs.
3. Metabolic effects other than those on blood sugar homeostasis; as effects on liver, kidney and thyroid and effects on acid/base balance (lactic acidemia).

Panel Discussion

Moderator

Robert H. Areson, M. D., Associate Attending in Medicine, The Mountainside Hospital, Montclair.

4:00 p.m.

Visit to Exhibits

Wednesday Morning, May 20, 1964

DERMATOLOGY

Seymour L. Hanfling, M.D., Chairman, East Orange

Hugh McCulloch, Jr., M.D., Secretary, Plainfield

9:30 a.m.

Election of Officers

9:45 a.m.

Syphilis—An Old Enemy on the March

William J. Dougherty, M.D., Director, Division of Preventable Diseases, New Jersey State Department of Health, Trenton

Infectious syphilis rates in New Jersey continue to be alarmingly high; however, the upward trend in the infectious syphilis incidence that started in New Jersey in 1957, and continued through 1962, leveled off in 1963. There were 1187 such cases reported in 1963, 2% fewer than the 1202 cases reported in 1962. This slight decrease is not considered to be significant, and thus intensive surveillance of primary secondary syphilis continues to have a high priority.

In 1963, 617 or 52% of the 1187 cases were reported by private physicians. The percentage of primary and secondary syphilis cases reported by private physicians compared to clinic cases has increased from 38% in 1960 to 53% in 1963. This continued increase in private physician reporting is testimony to the effectiveness of physician cooperation resulting from the physician visitation program that in three years reached out to approximately 5,000 physicians. Physicians are being encouraged to become active participants in the epidemiologic process by requesting an epidemiologic interview of their patients on the day of diagnosis of primary secondary syphilis. If the patient is interviewed in the physician's office while still concerned about his disease, he is psychologically ready to reveal the sources of his infection. Physicians cooperating in this activity contribute to the control of infection by assisting in reducing the time that infectious contacts are free to spread diseases.

10:05 a.m.

Hirsutism and Electrolysis

Harry C. Goldberg, M.D., Senior Attending in Dermatology, Muhlenberg Hospital, Plainfield

Co-Author: Seymour L. Hanfling, M.D., East Orange

The causes of hirsutism as a major problem are classified and briefly described. The importance of identifying possible tumors, hyperplasias, and metabolic disturbances by history and well evaluated laboratory studies is emphasized. Where none of these causes are present or correctable, other means of removing the unwanted hair are described.

Electrolysis as a general term for electrical epilation is discussed. New histo-pathologic findings, the extent of tissue destruction, improvements in the type of equipment, evaluation of the various technics and results are covered. Temporary methods of hair removal with or without electrolysis are described. The psychological benefits are covered.

10:25 a.m.

Nummular Eczema and Its Correlation With Athlete's Foot

Wilbert Sachs, M.D., Director of Dermatology, Passaic General Hospital

The presentation summarizes the clinical and histopathologic features of nummular eczema and some of its variations. Nummular eczema is the most common skin disease and may develop anywhere on the body. On the feet it has been diagnosed as dermatophytosis, tinea pedis, or athlete's feet. Many reasons are discussed to show that a fungus may not be the primary etiologic factor, and we may have to reconsider our concept of this dermatosis.

10:45 a.m.

Discussion

11:00 a.m.

Occupational Dermatology

Samuel Peck, M.D., Director of Dermatology, The Mount Sinai Hospital, New York, N. Y.

Occupational Dermatology comprises a group of dermatologic diseases which are due to environmental exposures. For this reason etiologic factors in many puzzling dermatologic syndromes can be ascertained more easily. The basic physiology and pathology, as well as the approach to diagnosis and treatment, do not differ essentially from those diseases of similar nature seen among the general population.

Specific suggestions for diagnosis and prevention are given, as well as a discussion of secondary factors contributing to prolongation of occupational dermatoses.

11:45 a.m.

Visit to Exhibits

GASTROENTEROLOGY AND PROCTOLOGY, OTOLARYNGOLOGY, RADIOLOGY

Joint Session

Gastroenterology and Proctology

Ferdinand G. Weisbrod, M.D., Chairman, East Orange

James Edson, M.D., Secretary, Paterson

Otolaryngology

James H. Spillane, M.D., Chairman, Phillipsburg
Julio T. Noguera, M.D., Secretary, Neptune

Radiology

W. Laurence Bonnet, M.D., Chairman, Trenton
Philip D. Gilbert, M.D., Secretary, Camden

9:30 a.m.

Election of Officers

9:45 a.m.

Symposium—The Esophagus

Use of Cinefluorography in Esophageal Abnormalities

George N. Stein, M.D., Clinical Professor of Radiology, Graduate School of Medicine, University of Pennsylvania; Associate Director, Department of Radiology, The Graduate Hospital, Philadelphia, Pa.

Cinefluorography is an important and useful method for the study of the esophagus; for certain lesions, the roentgen examination can be considered incomplete without the use of this technic. It affords the radiologist an opportunity repeatedly to study visual observations of motility that cannot be appreciated during conventional fluoroscopy and cannot be recorded by ordinary radiography.

This presentation illustrates the above points and, in addition, stresses the use of cinefluorography in distinguishing between carcinoma and achalasia, in evaluating dysfunction of the closing mechanism of the lower esophagus and in correlating observations of abnormalities with patient's symptoms.

The Clinical Evaluation of Esophageal Disease

Louis A. Brodkin, M.D., Associate in Medicine, Newark City Hospital

Of the entire gastro-intestinal tract, the esophagus is the simplest both anatomically and physiologically. This small simple organ plays a tremendous part in our well-being and normal existence.

Study of diseases of the esophagus has been diluted among many sub-specialties: otolaryngology, endoscopy, radiology, thoracic surgery and gastroenterology; but in recent times it has become a prime responsibility of the gastro-enterologist, who is probably the first to encounter the patient.

Since the panel of speakers at this meeting will expertly discuss the anatomy, physiology, radiology, and endoscopy, it is the purpose of this paper to elaborate on the clinical aspects of esophogeal disease, its symptomology and complications.

The Diagnostic Value of Esophageal Motility Studies

Bernard R. Cohen, M.D., Research Assistant in Gastroenterology, The Mount Sinai Hospital, New York, N. Y.

Measurement of esophageal motility has been developed to the stage of distinct clinical usefulness. Where results of x-ray and esophagoscopic examination are inconclusive, motility studies may provide specific diagnostic information. Functional disorders of the esophagus are best identified and characterized by this means. Representative motility tracings and x-rays of problem cases will be presented and discussed to illustrate the specific value of esophageal motility study in a clinical setting.

Endoscopy in the Diagnosis of Esophageal Disorders

Joseph P. Atkins, M.D., Clinical Professor of Bronchology and Esophagology, University of Pennsylvania School of Medicine; Chairman, Department of Bronchology, Esophagology, and Laryngeal Surgery, The Graduate Hospital, Philadelphia, Pa.

This is a film presentation which demonstrates the techniques of endo-esophageal therapy used at the University of Pennsylvania broncho-esophagological clinics. The endo-esophageal treatment of various esophageal diseases will be presented. Esophageal strictures, post-surgical complications, achalasia, esophageal varices, and the mechanical therapy of esophagitis will be considered.

Thomas F. Flynn, Jr., M.D., Attending in Otolaryngology, Underwood Hospital, Woodbury

Edgar P. Cardwell, M.D., East Orange; Attending in Rhinology and Broncho-Esophagology, Presbyterian Hospital Unit, United Hospitals of Newark

Will present cinefluoroscopic demonstrations of:

1. An interesting hiatus hernia with traction diverticulum.
2. A cork-screw esophagus.
3. An unusual Zenker Diverticulum.
4. A pseudodiverticulum.

In addition to this, will have eight 35 mm. slides for projection, illustrating carcinoma of the cervical esophagus.

11:45 a.m.

Visit to Exhibits

RHEUMATISM

Edwin S. Woolbert, M.D., Chairman, Pleasantville
Lawrence J. Denson, M.D., Secretary, Hackensack

9:30 a.m.

Election of Officers

9:40 a.m.

Symposium—Diagnostic Aids in Rheumatic Diseases

The Foot in Rheumatic Diseases

John J. Calabro, M.D., Associate Professor of Medicine, Seton Hall College of Medicine; Director, Division of Rheumatology, Medical Center, Jersey City

Joints which are affected frequently by arthritis are those of the foot and hand. Though it is well established that the appearance of the hand may aid the physician in differentiating the type of arthritis present, it is little recognized that changes seen in the foot may also assist in the differential diagnosis. With this view in mind, and in the hope that it may arouse interest in an area often neglected, the differential features of arthritis in the foot will be outlined.

The Hand in Rheumatic Diseases

L. Maxwell Lockie, M.D., Professor of Therapeutics, State University of New York at Buffalo, School of Medicine, Buffalo, N. Y.

Rheumatoid arthritis is a systemic disease, which locally involves the joint synovial membrane. The alterations of soft tissue, cartilage, and bone are a reflection of this pathology.

A selected group of proved adult rheumatoid arthritics was reviewed with the early clinical and roentgen manifestations described. Routine studies of the wrists, hands, and feet of all suspected cases have been done in addition to the symptomatic joints.

We have radiographed specimens in various projections in an attempt to demonstrate the invasive nature of the diseased synovial membrane. Photomicrographs substantiate this hypothesis.

This information can be very helpful in early differential diagnosis.

The X-ray in Rheumatic Diseases

Yu-Shang Chang, M.D., Chief of Radiology, Hackensack Hospital

The role of x-rays as diagnostic aides in rheumatism will be discussed with emphasis on early changes in rheumatoid arthritis.

A brief review of differential diagnosis will also be presented.

The Laboratory in Rheumatic Diseases

John Abruzzo, M.D., Instructor in Medicine, Seton Hall College of Medicine, Jersey City

The erythrocyte sedimentation rate (ESR), the rheumatoid factor (RF), the anti-nuclear antibodies, and the anti-streptolysin titer will be discussed as they relate to the diagnosis and management of rheumatic fever, rheumatoid arthritis, and lupus erythematosus.

Roundtable Discussion

11:45 a.m.

Visit to Exhibits

Wednesday Afternoon, May 20, 1964

ANESTHESIOLOGY, CARDIOVASCULAR DISEASES, CHEST DISEASES

Joint Session

Anesthesiology

Robert A. Murphy, M.D., Chairman, Mount Holly
Bernard C. Kaye, M.D., Secretary, Long Branch

Cardiovascular Diseases

Norman Reitman, M.D., Chairman, New Brunswick
Angelo J. Migliori, M.D., Secretary, Trenton

Chest Diseases

Sanford M. Lewis, M.D., Chairman, Newark
Meyer T. Weissman, M.D., Secretary, Elizabeth

1:00 p.m.

Luncheon—New Jersey Chapters, American College of Cardiology, and American College of Chest Physicians

Reservations: Norman Reitman, M.D.
155 Livingston Ave., New Brunswick

2:00 p.m.

Election of Officers

2:15 p.m.

Symposium—Prelude to Cardiac Surgery

Moderator

Dwight E. Harken, M.D., Professor of Clinical Surgery, Harvard Medical School; President, American College of Cardiology, Boston, Mass.

Cardiologist

Harper K. Hellems, M.D., Professor of Medicine and Director, Division of Cardiovascular Diseases, Seton Hall College of Medicine; Director, Thomas J. White Cardiopulmonary Institute, B. S. Pollack Hospital for Chest Diseases, Jersey City

Discussor: Harry A. Kaplan, M.D., Trenton

Prior to cardiac surgery a precise and definitive diagnosis should be arrived at by appropriate cardiovascular studies including cardiac catheterization and angiocardiography.

In the pre-operative management of the cardiac problem, attention should be directed to the status of the cardiac function and assurance that the patient is in an optimal physiological condition to undergo surgery. This can be accomplished by ade-

quate rest, digitalis, sodium restriction, and diuretic therapy—all appropriately designed to meet individual needs.

Perhaps of greater importance than the pre-operative management of the cardiac patient is the meticulous attention to detail in therapy required in the post-operative period by the surgeon and cardiologist.

Chest Physician

Thomas J. Ormsby, M.D., Director of Pulmonary Physiology Laboratory, St. Michael's Hospital, Newark

Discussor: Saul Lieb, M.D., Newark

The increasing complexity of current surgical procedures—particularly on the heart, lung, and brain —together with performance of surgery, both elective and imperative, on an increasing number of senior citizens in our communities demands adequate pre-operative pulmonary function testing and timely post-operative assessment of the ventilatory and metabolic status through blood gas and electrolyte studies. Modern instrumentation permits this knowledge to be gained rapidly and simply. Technics and essential parameters of such studies will be discussed.

Anesthesiologist

Thomas H. Cannard, M.D., Consultant in Anesthesiology, Veteran's Administration Hospital; Assistant Professor of Anesthesiology, The University of Pennsylvania School of Medicine, Philadelphia, Pa.

Discussor: William H. Spencer, Jr., M.D., Short Hills

OPHTHALMOLOGY

William Rubin, M.D., Chairman, New Brunswick
Paul H. Pettit, M.D., Secretary, Ocean City

2:00 p.m.

Election of Officers

2:15 p.m.

Panel—Strabismus: Treatment of Eso-Deviations With and Without Amblyopia

Suggestions for the Correction of the Patho-Physiology of Strabismus

Arthur Linksz, M.D., Clinical Professor of Ophthalmology, New York University School of Medicine; Attending in Surgery, Manhattan Eye and Ear Hospital, New York, N. Y.

Eso-deviations without amblyopia usually start later in life and are mostly accommodative in nature. The therapy is conservative. Eso-deviations with amblyopia are the end result of complex patho-physiologic adjustment reactions, which are both sensory and motor in character. The technics developed to combat amblyopia essentially deal with these patho-physiologic adjustment reactions: suppression, eccentric fixation, anomalous correspondence. Together they are now called pleoptics. The lecture will deal mainly with the mechanism of the development of the adjustment reactions, and the rationale of the different treatment technics constitutes the topic of this talk.

Surgery of Eso-Deviations

Alfonse A. Cinotti, M.D., Professor of Surgery and Director of Ophthalmology, Seton Hall College of Medicine; Chief of Ophthalmology, Medical Center, Jersey City

The aim of surgery for eso-deviations is to align the visual axes after thorough optical, medical, and orthoptic treatments.

The factors which are important in preoperative planning are age of patient, duration and variability of the squint, angle of deviation, the A.V. accommodative portion, presence of amblyopia, nature of retinal correspondence, and the near point of convergence.

A discussion of the advantages and disadvantages of weakening and strengthening procedures, of symetrical versus asymetrical surgery, and the various factors influencing the amount of surgery will be undertaken.

Effective Use of Drugs in Strabismus

Irving H. Leopold, M.D., Professor and Head of Department of Ophthalmology, The Graduate School of Medicine, University of Pennsylvania; Medical and Research Director, Wills Eye Hospital, Philadelphia, Pa.

In 1896, Javal demonstrated that locally instilled Pilocarpine as well as Eserine could reduce the deviation of accommodative esotropia. In the intervening years, parasympathomimetic agents have been tried with varying success in the treatment of both accommodative and nonaccommodative esotropia.

The anticholinesterase agents have received most attention recently. Their pharmacologic action allows prolonged effects. The induced miosis and cyclotonia without central accommodative effect are among the helpful actions. All of these agents have undesired side effects as well as advantages.

Pre- and Post-Operative Management of Strabismus Associated with Amblyopia

William Rubin, M.D., Chairman, Department of Ophthalmology, Middlesex General Hospital, New Brunswick

Complete rehabilitation of the child with strabismus requires not only precise surgical technique but also a correction of the underlying functional disorders.

The amblyopia of varying degree which very early accompanies strabismus in a majority of cases must be our first consideration. Occlusion, atropinization, miotics, and the proper correction of refractive errors must all be employed judiciously. Most small angle deviations, treated when discovered with reverse prism and calibrated occulsion, can be completely eliminated. This simple technic may be used before, and immediately after, surgery with gratifying results, as shown by a tabulated report of 118 consecutive cases of strabismus with small angles of deviation. The truly successful cases show no angle of deviation, centric fixation in both eyes, rather equal visual acuity, and useful levels of stereopsis.

Question and Answer Period

PSYCHIATRY AND NEUROLOGY

David J. Flicker, M.D., Chairman, Newark
Eugene Revitch, M.D., Secretary, Plainfield

2:00 p.m.

Election of Officers

2:10 p.m.

Home Care of the Mentally Ill—A Coordinated Team Approach in the Community Health Program

William Furst, M.D., Attending in Psychiatry, East Orange General Hospital

Discussor: Evelyn P. Ivey, M.D., Morristown

It has become evident that there will never be enough hospitals to care adequately for the increasing numbers of people who require highly specialized attention. The program described in this paper appears to be the logical approach. Statistical analysis of 151 patients cared for at home by trained Home Makers during 1963-1964 is evaluated. The Chr-Ill Service Inc., sponsored by the Essex County Medical Society, is offering the first medically sponsored coordinated home care program for the mentally ill in the country.

2:40 p.m.

Sex Murder and the Potential Sex Murderer

Eugene Revitch, M.D., Plainfield; Attending in Psychiatry, New Jersey Diagnostic Center, Menlo Park

The purpose of this study is to evaluate prediction and dynamics of unprovoked sexual violence and murder committed by males against females. The sexual nature of these acts is frequently hidden. The review of literature, the newspaper accounts, and the detailed study of 33 assaults and 9 murders examined by the author at the Diagnostic Center indicate that choking, inflicting knife wounds, and battering the victims are the most common methods of attack. Evisceration and mutilation of the body with antropophagy were recorded in literature. Fetishism of female underwear, previous offenses of breaking and entering commited in bizarre circumstances, sadistic fantasies, mutilation of animals, and previous minor assaults on females are prognostic signs whose importance is usually overlooked by the sentencing judges and examining psychiatrists. Ambivalence to mother, preoccupation with maternal sexual demeanor, and hatred of females are the dynamic factors underlying these acts.

3:05 p.m.

Acknowledged But Unmet Needs—An Administrative Dilemma

Lloyd W. McCorkle, Ph.D., Commissioner, New Jersey Department of Institutions and Agencies, Trenton

Discussor: Jay W. Fidler, M.D., Plainfield

Seminar on Red Cells

You are invited to a conference on "Red Cell and Platelet Survival" to be held Tuesday evening May 26 at 8:00 p.m. at the Community Blood Bank, 20 Hudson Place, Hoboken. Dr. Max Strumia of the Bryn Mawr Hospital will be the essayist. This will be followed by a talk on "Reduction of Stillbirth Incidence in Hemolytic Disease" by Dr. Arthur Sawitsky of the Long Island Jewish Hospital.

Informational Exhibits

Exhibit Hours:
9:00 a.m. - 5:00 p.m., Monday and Tuesday
9:00 a.m. - 3:00 p.m., Wednesday
May 18, 19, and 20, 1964

The Smoking Habits of School Children

Seymour F. Kuvin, M.D., Morristown

The smoking habits of students in the 7th, 8th, and 9th grades were studied. The incidence of smoking and reasons for smoking are demonstrated.

The aim of this study was to determine why young school children are smoking, and to stimulate the establishment of anti-smoking clinics for children. An anti-smoking clinic technic used on school children is demonstrated.

Current Clinical Research of the National Institutes of Health

Clifton K. Himmelsbach, M.D., National Institutes of Health, Bethesda, Md.

The highlight of this exhibit is a continuous slide projection of color transparencies, which present pictures of the Clinical Center's patient care facilities. Eight large circular panels describe with photographs and text some of the major areas of clinical research currently being conducted at the National Institutes of Health, including an explanation of the procedures for physicians to follow in referring patients to the Clinical Center.

Preventable Diseases

William J. Dougherty, M.D., Director, Division of Preventable Diseases, New Jersey State Department of Health, Trenton

Three panel, self-supporting exhibit unit describing problems and control measures related to preventable diseases.

Your Public Health Nurse

New Jersey State Department of Health, Trenton

This exhibit presents illustrations and related copy outlining (1) the qualifications and training of the public health nurse; (2) the function of the public health nurse; and (3) the types of service provided by public health nursing personnel.

Model Program of Diabetes Detection

Anthony J. Perrone, M.D., Chairman, Diabetes Committee, Essex County Medical Society, East Orange

Exhibit demonstrates intensive year-round diabetes detection program—perhaps the first of its kind in U. S. Called "model of planning and organization," by Dr. Glen W. McDonald, Chief, Diabetes Program, U. S. Public Health Service, the program is being carried out in East Orange, N. J., under the sponsorship of the Essex County Medical Society. Venous blood is tested by Clinitron at East Orange Health Department; positives (glucose above 130 mgm. per cent) are re-tested by Auto-Analyzer at New Jersey State Department of Health. All positive screenees are referred to their private physicians for final diagnosis. Printed displays, leaflets, exhibits, etc. were supplied as a public service by The Upjohn Company to promote early detection of diabetes. IBM data on detected cases illustrate effectiveness of community-wide long-term detection campaign. Educational materials for physician and laymen, photomurals of selective groups being screened, posters, pharmacy displays, and leaflets show how such a program can be developed and sustained.

Home Care of the Mentally Ill

William Furst, M.D., Chr-Ill Service (Essex County Service for the Chronically Ill), East Orange

Pictorial and graphic portrayals of services provided by Home Makers for mentally ill persons cared for in own home.

The Patient Centered Hospital

Theodore D. Spritzer, M.D., Evelyn G. Palm, Gordon A. Friesen, Edward H. Noakes, A.I.A., Raritan Valley Hospital, Dunellen

Models pertaining to Raritan Valley Hospital, under construction in Greenbrook, Dunellen, N. J., indicating a new concept in hospital programming and construction with emphasis on automation of services bringing services to the patient instead of patient to the services. This is the first hospital in New Jersey being developed along this new concept.

Current and Projected Rehabilitation Services Offered by the Betty Bacharach Home for Afflicted Children

David B. Allman, M.D., Martin Green, M.D., Carter Zeleznik, M.A., Atlantic City

The purpose of this exhibit is to inform New Jersey physicians as to the rehabilitation and convalescent services available at the Betty Bacharach Home, and to present statistical evaluations of results obtained in the various medical and surgical diseases treated at the Betty Bacharach Home in the past five years.

Visiting Homemaker Service of New Jersey

Mae R. Brown, ACSW, Executive Director, Trenton

Presents a graphic picture of a Homemaker community service . . . "to the end that nursing and medical care being furnished the chronic sick in their own homes shall be improved in every manner possible." This service was established to perform one of the duties stipulated in the 1952 "Prevention of Chronic Illness Act" (Chapter 102, P.L. 1952). The exhibit displays the geographical areas where eighteen Visiting Homemaker Services are located in sixteen of the twenty-one New Jersey counties. This large geographical area of Visiting Homemaker Service indicates that five hundred Homemakers extend qualitative service over a wider spread of the New Jersey population than any other state at the present time.

The Society for the Relief of Widows and Orphans of Medical Men of New Jersey

James E. D. Gardam, M.D., President, Belleville

The oldest society of its kind in this country presents an educational exhibit designed to acquaint physicians with the benefits to be derived from membership. The Society is a charitable organization, operated by physicians to provide relief for widows and orphans of deceased members. The exhibit consists of charts and educational literature.

Civil Defense Emergency Training Hospital

Committee on Disaster Medical Care, The Medical Society of New Jersey; Division of Civil Defense Medical and Health Services, New Jersey State Department of Health, Trenton

The Civil Defense Emergency Training Hospital shows the material and equipment available for physicians in the improved CDEH. Newer concepts have evolved in the use of the 200-Bed CDEH. In addition to its availability near a large area of disaster, this hospital may be used to replace a fixed hospital that has become unavailable; the medical supplies may be used as back-up material to replenish a fixed hospital; it may also be used for the establishment of first-aid posts in communities. The improved CDEH has sufficient medical supplies for a 30 day capability of operation. These hospitals are now prepositioned throughout the State of New Jersey.

JEMPAC

Jersey Medical Political Action Committee

This is an exhibit put out by AMPAC, designated to alert the physician to the threat of increasing governmental intervention and control in the practice of medicine. Will include taped talks by four congressmen.

Association of American Physicians and Surgeons

Theodore Pollock, M.D., Passaic

Material illustrating the goals and aims of the Association of American Physicians and Surgeons for the purpose of securing new members.

The Screening of Hearing in School Children

Committee on the Conservation of Hearing and Speech, The Medical Society of New Jersey

Review of type of hearing loss you would find in five to seventeen age group. Article "The Screening of Hearing in School Children" to be distributed.

Scientific Exhibits

Exhibit Hours:

9:00 a.m. - 5:00 p.m., Monday and Tuesday

9:00 a.m. - 3:00 p.m., Wednesday

May 18, 19, and 20, 1964

A New Industrial Disease—Chloracne With Porphyria Cutanea Tarda

Roger H. Brodkin, M.D., Jacob Bleiberg, M.D., Newark Beth Israel Hospital

An outbreak of chloracne and porphyria cutanea tarda was observed in a factory which was manufacturing the common weed killers 2, 4, dichlorobenzene and 2, 4, 5, trichlorobenzene. The clinical features, course, and treatment of this problem are presented and illustrated with photographs.

Preliminary Studies in the Therapy of Strabismic Amblyopia

William Rubin, M.D., New Brunswick; Robison D. Harley, M.D., Atlantic City

The purpose of this study is to show that complete rehabilitation of the cross-eyed child requires not only precise surgery but also correction of defects in visual function.

Newer pleoptic and orthoptic technics permit marked improvement in vision of the deviating eye as well as the establishment of binocularity. In many cases of amblyopia high visual acuity, fusion and good depth perception can now be promised.

Proper evaluation of strabismus now demands, in addition to pre-operative measurements of the angle of deviation in all fields of gaze, accurate observations of the type and extent of eccentric fixation. It will be shown how the fixation point in strabismic amblyopia changes during therapy in successful cases. It will be demonstrated how patients with small angle eso- or exo-deviations often, after seemingly adequate surgery, are found to be slightly eccentric and monocular, yet will respond to a simple optical device. Using a reverse prism of suitable power incorporated into the patient's glasses, as the better eye is partially occluded, will frequently result in parallel eyes, heightened visual acuity, centric fixation, and useful binocular function.

Methods of correcting the retino-cerebral response by direct foveal stimulation after dazzling the perimacular region will be compared with imprinting an after-image upon the fovea to permit effective eye, brain, and hand coordination.

In both technics, it is the defective eye which is occluded. Satisfactory occlusion is obtained by the dark patch, cloth adhesives, or, in suitable cases, by means of a contact lens with distorted optics.

Approximately 60% of patients with the partial blindness of amblyopia may regain 20/30 vision or better. More than 40% may acquire binocular single vision with depth perception.

Mammography in the Early Detection of Diseases of the Breast

Anthony G. B. Borden, M.D., Simon M. Berger, M.D., Jacob Gershon-Cohen, M.D., Albert Einstein Medical Center, Northern Division, Philadelphia, Pa.

A demonstration of various types of breast pathology —ranging from radiographically apparent lesions to less apparent and non-identified radiographic lesions which still turn out to be malignancies.

The Major Uncontrolled Cancer—Carcinoma of the Breast

Joseph I. Echikson, M.D., Chairman, Professional Information Committee, American Cancer Society, New Jersey Division, Inc., Newark

The exhibit directs attention to the breast cancer problem, which is still largely an unanswered one in this country. Breast cancer is the number one cancer in women in the United States, both in incidence (63,700 new cases estimated for 1963) and mortality (24,700 deaths anticipated in 1963), and overall death rates have not declined despite more than 60 years of surgical and public educational efforts. The varying methods of management of suspected or actual breast cancer are outlined, and the value of early diagnosis and proper treatment reaffirmed.

Present Concepts of Mitral Valve Surgery

Robert S. Litwak, M.D., Howard L. Gadboys, M.D., Ralph Lev, M.D., The Mount Sinai Hospital, New York, N. Y.

Many variables influence the final decision to operate upon mitral stenosis by closed or open heart technics, and often the advantages of the closed method are offset by the inability to do a completely satisfactory repair. Therefore, it is our practice to have the heart-lung machine on stand-by for all closed procedures. Twenty-three patients with pure mitral stenosis were prepared for closed mitral commissurotomy with heart-lung machine stand-by. Seventeen had a satisfactory closed mitral commissurotomy; however, 6 required open heart repair after closed exploration (of which 5 had mitral valve replacement). There was one death. These findings substantiate our conviction that closed mitral commissurotomy should be done only with heart-lung machine stand-by.

Repair of Ventricular Septal Defects Via the Atrium

Robert S. Litwak, M.D., Howard L. Gadboys, M.D., Ralph Lev, M.D., The Mount Sinai Hospital, New York, N. Y.

Ventricular septal defects have been repaired through a right ventricular incision for some time. However, this incision has distinct disadvantages of (1) decreasing the work capacity of the right ventricle, (2) producing cardiac muscle injury similar to a myocardial infarct by ECG, (3) injuring significant branches of the right coronary artery, (4) limited exposure of high ventricular septal defects. Utilizing a right atrial approach and incising the circumferential margin and retracting the septal leaflet of the tricuspid valve, the major disadvantages listed above are obviated. This is especially significant in high right ventricular pressure patients. Our experience with 8 cases is presented. There were no deaths.

An Arterial Graft of Biologic Origin

Norman Rosenberg, M.D., John Henderson, M.D., Geoffrey H. Lord, D.V.M., James W. Bothwell, Ph.D., Eugene R. L. Gaughran, Ph.D., Middlesex General Hospital, The Johnson & Johnson Research Foundation, New Brunswick.

The preparation of a biologic arterial graft from bovine arteries is demonstrated. Enzymatic debridement of muscle and elastica components leaves a strong collagen prosthesis of low reactivity.

Two-year observations in the dog are presented.

The Correction of Postgastrectomy Malabsorption and Dumping By a Jejunal Interposition Operation

Charles Wilmer Wirts, M. D., Franz Goldstein, M.D., John Y. Templeton, M.D., Charles Fineberg, M.D., The Jefferson Medical College of Philadelphia, Pa.

Investigations in our gastrointestinal division for the past four years suggested that bacterial overgrowth due to stasis in the afferent limb of a Billroth II anastomosis contributes to postgastrectomy symptoms. Treatment with antibiotics of selected patients frequently produced striking but temporary improvement. Therefore, surgical attempts to produce gastroduodenal continuity seemed warranted to overcome stasis in the afferent loop and regain normal physiologic stimulation to the pancreas and permit adequate mixing of food and enzymes.

The exhibit consists of charts listing the symptoms, etiologic concepts, and diagnosis of postgastrectomy sequellae as well as the results in the medical assessment and management of 30 postgastrectomy patients (15c and 15s steatorrhea) and 9 postgastrectomy patients who had excellent relief of symptoms following jejunal interposition. Transilluminated colored photographs will illustrate clinical findings of advanced postgastrectomy malnutrition, details of operative findings, and x-ray appearance of the gastroenterostomy area before and after operation.

Plasmin Activation of Peptidases—A New Concept of Oral Enzyme Therapy

Irving Innerfield, M.D., Bergen Pines County Hospital, Paramus; Fairleigh Dickinson University, Teaneck

This exhibit is concerned with the most recent advances in knowledge about the activity of a proteolytic enzyme administered orally.

The four cardinal manifestations of inflammation are reviewed and related to the pharmacologic activity of a potent kinin, which is believed to "trigger" the inflammatory process. The proteolytic enzyme is then shown to antagonize the action of the kinin.

Efforts are made to demonstrate in humans by means of photographs, charts, and graphs a controlled experimental situation proving that the kinin is an active agent concerned with pain and inflammation, and showing that the administration of the enzyme inhibits the inflammatory process as well as the pain.

New Horizons in the Therapy of Osteomyelitis

Leon G. Smith, M.D., St. Michael's Hospital, Newark

The purpose of this trial was to determine whether nafcillin, a new semi-synthetic penicillin, might be as effective as penicillin G prior to the emergence of penicillin resistant organisms in the management of osteomyelitis.

Eighteen patients with acute and chronic osteomyelitis, culturally proven to be caused by Staph, aureus (coagulase positive) and resistant to penicillin G, were treated with nafcillin. The results are demonstrated by serial cultures and x-rays, and other clinical experience regarding treatment of osteomyelitis with nafcillin.

Continuing experience to date indicates that nafcillin is a valuable drug in the management of osteomyelitis, particularly in long-term therapy of chronic osteomyelitis.

Tendinitis and Tenosynovitis

Irving L. Sperling, M.D., Maplewood

This exhibit will attempt to demonstrate graphically the various forms of Tendinitis and Tenosynovitis. The pathological and clinical changes will be illustrated as well as the various methods of treatment. The local injection treatment will be stressed, particularly the beneficial effects of triamcinolone acetomide. Statistics will be presented showing the efficacy and safety of these procedures.

Massive Obesity—An Approach to Its Control

Seymour K. Fineberg, M.D., Director of Medicine, Harlem Hospital, New York, N. Y.

An intensive initial treatment of massive "intractable" obesity with formula diet, anorexigenic, and effective diuresis for periods up to one year. Patients weighed two to four times normal; average for the group was 350 pounds. Losses of as much as 130 pounds in 27 weeks were obtained. All patients but one exhibited edema during treatment. The retention of water simulates intractability to treatment by masking actual fat loss. Total fasting is far less preferable to this safer, more physiological method. Moderated control must continue for a life-time as in treating diabetes and hypertension.

Thiopurines as Immunosuppressive Agents

J. K. Weston, M.D., G. Hitchings, Ph.D., G. B. Elion, M.S., Wellcome Research Laboratories, Burroughs Wellcome & Co. (U.S.A.) Inc., Tuckahoe, N. Y.

A presentation of recent developments in chemotherapeutic research with 6-mercaptopurine and the experimental drugs, thioguantine and azathioprine. Their effectiveness is shown in "antibody suppression," "autoimmune diseases," and in "organ transplants."

Three-Year Study of Management of Peptic Ulcer

Fred J. Phillips, M.D., David M. Shoemaker, M.D., Chiu Ling Chai, M.D., Quakertown, Pa.

To test under controlled conditions over a three-year period the efficacy of a regimen for minimizing the frequency and severity of peptic ulcer attacks in individuals with proved ulcers. The regimen consists of antacids, bland diet, and anticholinergic drug. Other therapy is also discussed. The criteria used are time to bring ulcers under control, duration of hospitalization, and those requiring special medical care in addition to the recommended regimen.

The concept of a specific, rational approach to peptic ulcer has proved most successful as compared to an empirical type of therapy. Statistical objective proof of reduction in time loss from work or in hospital from 60% in control group to 6% in test group.

Treatment of Malignant Lymphomas

David W. Molander, M.D., George T. Pack, M.D., New York, N. Y.

The cardinal symptoms, signs, age distribution, sex distribution, organ system involvement, complications of 567 patients with lympho sarcoma, and 316 patients with Hodgkin's Disease are demonstrated.

The principles of therapy used are outlined—including radical surgery in selected instances, radiation therapy, and chemotherapy.

The end results of these two groups are illustrated.

Gastroscopy

Francis X. Keeley, M.D., Robert L. Breckenridge, M.D., Our Lady of Lourdes Hospital, Camden

Exhibit will show 8 mm. silent color motion pictures of the normal stomach and various disease states, including benign gastric ulcers in various locations, including greater curvature, gastric malignancies, marginal ulcer, and localized giant rugal hypertrophy. Equipment will be shown and technic illustrated.

Progress in Polio Virus Vaccine Research

James M. Ruegsegger, M.D., Charles J. Masur, M.D., Pearl River, N. Y.

Research has produced a live, oral vaccine that confers simultaneous immunity against Type 1, Type 2, and Type 3 poliomyelitis. This vaccine consists of specifically proportioned amounts of the three Sabin strains.

The exhibit describes briefly the steps that led to development of this vaccine from monovalent vaccines. It describes in greater detail the clinical trial of the trivalent vaccines in mass immunization programs. Safety and efficacy is demonstrated, and the duration of immunity conferred is shown to be significant.

Coagulation Defects During Portasystemic Shunts

Carlo E. Grossi, M.D., Louis M. Rousselot, M.D., William F. Panke, M.D., St. Vincent's Hospital, New York University School of Medicine, New York, N. Y.

Coagulation defects were studied in 240 patients with cirrhosis of the liver. One hundred and eight of these, with symptoms of bleeding varices or ascites, were subjected to portacaval shunt for relief of portal hypertension. Clinically significant coagulation defects were found in 14 per cent of the patients. In these 14 patients, unexpected generalized oozing occurred during surgery. All these patients had marked fibrinolysis and low plasma fibrinogen. The fibrinolytic inhibitor Epsilon Amino Caproic Acid was used successfully in arresting the oozing in 10 patients. Various modalities for the control of fibrinolysis during and after portacaval shunt are presented. Management of concomitant hypersplenism is discussed.

Disability Evaluation for Retirement

Earl F. Hoerner, M.D., Disability Determination Service, New Jersey Rehabilitation Commission, Newark

The exhibit sets forth the steps needed to make social security disability determinations for 380,000 claims annually. Through a series of transparencies, the exhibit shows how reports from treating physicians are used to assess remaining capacity for physical and mental activities; how this remaining capacity is equated with the demands of jobs for which the individual is qualified.

Cardiopulmonary Resuscitation

Alvin A. Florin, M.D., Heart and Circulatory Disease Program, New Jersey State Department of Health, Trenton

Proper technics of cardiopulmonary resuscitation utilizing external cardiac compression and expired air ventilation.

Refractory Heart Failure—Pathophysiology and Therapy

Albert N. Brest, M.D., Robert Seller, M.D., Gaddo Onesti, M.D., Charles Heider, M.D., John H. Moyer, M.D., The Hahnemann Medical College and Hospital of Philadelphia, Pa.

The pathophysiology of refractory heart failure involves an interplay of cardiac, renal hepatic, adrenal and pituitary dysfunction. When routine anticongestive measures (bed rest, salt restriction, digitalis, and single diuretic regimens) fail, advanced therapeutic maneuvers must be employed. These include combined diuretic regimens, mechanical means (dialysis and paracentesis), and radioiodine. The various therapeutic measures are described in detail.

Pulmonary Cysts

Samuel Cohen, M.D., B. S. Pollak Hospital for Chest Diseases, Jersey City

Pulmonary cysts are being recognized with increasing frequency because of (1) more frequent routine use of the chest x-ray film; (2) the use of chemotherapy for pulmonary infections; (3) increased recourse to exploratory thoracotomy permitting study of resected specimens. Pulmonary cysts are of clinical importance (1) because they are favorite sites for infection (a most common and important complication); (2) may produce hemoptysis; (3) rupture of a bleb or bulla may produce spontaneous pneumothorax and/or interstitial or mediastinal emphysema; (4) compression and/or destruction of lung by cysts may produce respiratory failure. These complications make it desirable, therefore, (1) to try to predict the future course of a pulmonary cyst; (2) to emphasize the management of the patient with par-

ticular reference to feasibility of surgical resection. Charts and transparencies are shown to visualize various types of pulmonary cysts, their behavior and management. Selection of cases is oriented (1) to patients that were operated upon and in whom pathological findings are available; (2) to patients who had long follow-up examinations but without surgery in whom the fate of the pulmonary cyst might be better evaluated.

Emphysema—When the Breath of Life Falters

Bohdan G. Giel, M.D., Assistant to the Chief, Division of Air Pollution, Public Health Service, United States Department of Health, Education, and Welfare, Washington, D. C.

This two-part exhibit acquaints the viewer with the chronic respiratory disease emphysema, and also with a current respiratory disease study in Alabama. Part I contrasts normal respiration with the abnormal breathing of an emphysematic. This contrast is accomplished through pulmonary movement and pulmonary pathology. An automatic repeating recorded message discusses pulmonary physiology and contrasts the sounds of normal breathing with those of an emphysema patient. (This message can be modified to suit the exhibit audience.)

Part II shows various aspects of a current statewide respiratory disease-air pollution research project, conducted by the Medical College and TB Associations of Alabama, in cooperation with the Division of Air Pollution of the Public Health Service. This unit revolves on a motor-driven turntable.

An Improved Technic for Postural Drainage

Ralph Lev, M.D., Paul G. Eshleman, Princeton

Postural drainage ofttimes is a lifesaving procedure in those patients who have retained pulmonary secretions. The greatest problem has been in obtaining the cooperation of the patients for this therapy. Frequently they are physically unable to perform it. A new device has been constructed, which has greatly facilitated the performance of this therapy and has resulted in actual eagerness of the patients to do their postural drainage. This has resulted in rapid and significant improvement in pulmonary function in patients who previously were uncomfortable or disabled. Using the same machine, treatment may be given in the hospital or at home. The apparatus will be demonstrated and case reports presented.

Cardiovascular Disease in Psychotics—Study No. 2

Daniel G. Melvin, M.D., Hillel M. Ben-Asher, M. D., C. Archie Crandell, M.D., Albert Abraham, M.D., New Jersey State Hospital, Greystone Park

This exhibit deals with the incidence of cardiovascular disease in psychotic patients at a state hospital. It depicts the incidence of disease in males and females and compares them with non-psychotic public groups.

A particularly interesting feature is the large number of people with heart disease found as a result of routine chest x-ray screening.

Sexual Offenses

Ralph Brancale, M.D., Eugene Revitch, M.D., New Jersey Diagnostic Center, Menlo Park

Two charts (25x18 inches) describing the New Jersey Sex Law and reporting the statistics of sexual offenders examined at the New Jersey State Diagnostic Center. One chart (approximately 25x18 inches) with classification of sexual offenses by type of offense. Two charts (half size of the previous charts) indicating statistics on use of force, disposition, and results.

Roentgen Changes in Early Rheumatoid Arthritis

David L. Berens, M.D., L. Maxwell Lockie, M.D., Ru-Kan Lin, M.D., Bernard M. Norcross, M.D., Buffalo General Hospital, Buffalo, N. Y.

Rheumatoid arthritis is a systemic disease, which locally involves the joint synovial membrane. The alterations of soft tissue, cartilage, and bone are a reflection of this pathology.

A selected group of proved adult rheumatoid arthritics were reviewed and the early roentgen manifestations described. Routine studies of the wrists, hands, and feet of all suspected cases have been done in addition to the symptomatic joints. These studies have been carried out with fine-grain film for better definition.

We have radiographed specimens in various projections in an attempt to demonstrate the invasive nature of the diseased synovial membrane. Photomicrographs substantiate this hypothesis.

Technical Exhibits

Exhibit Hours:

9:00 a.m. - 5:00 p.m., Monday and Tuesday
9:00 a.m. - 3:00 p.m., Wednesday
May 18, 19, and 20, 1964

Abbott Laboratories — Booth 39

Abbott Laboratories invites you to visit our exhibit. Our representatives will be happy to answer any questions you may have concerning our leading products and new developments.

Americana Corporation — Booth 63

We will be featuring the new 1964 edition of the *Encyclopedia Americana,* available to delegates on a special exhibit offer. You are cordially invited to drop by our booth, where our representatives will be happy to show you the new major revision and explain any details.

American Mutual Liability Insurance Co. — Booth 16

Mr. Joseph Britton, Manager, and Mr. Paul Stanton, Claim Manager, of the Professional Liability Insurance Department for New Jersey, will be pleased to answer any questions or discuss any problems relating to Professional Liability or Professional Premises Liability coverages.

Ayerst Laboratories — Booth 32

A most cordial invitation is extended to all physicians to visit the Ayerst Laboratories' booth, where we will feature Grisactin, Enzactin, Premarin Cream and Lotion, Mysoline, and Riopan. Our representatives will be on hand to discuss with you these products and any information you might desire on our other products.

Baby Service, Inc. — Booth 57

A warm welcome and a red rose await each visitor at the Baby Service booth. This hospitality for over ten years has made Baby Service a conversation piece at every meeting. The latest improvement in diaper service for home and hospital will be on display. Ask about our new layette service for hospitals.

E. & W. Blanksteen Agency, Inc. — Booths 5 & 6

Information and literature regarding The Medical Society of New Jersey's officially approved plans of disability, major medical, and life insurance are available at this booth.

The Borden Company — Booth 37

Borden's dermatologicals, unique amino acid therapy (reported to stimulate growth of epethelial tissue) in water washable, antiseptic creams. Methakote, Methatar, Methaphor, and Methaseptic. Infant formulas Bremil and Mull-Soy. New data on milk allergy concerning the use of Mull-Soy.

Burroughs Wellcome & Co. (U.S.A.) Inc. — Booth 51

Our trained representatives will be on hand with information concerning recent developments from the extensive research facilities of Burroughs Wellcome & Co. Of particular interest at this meeting are Neosporin and Cortisporin Creams for topical bacterial infections, Mantadil Cream for relief of itching, Actifed for respiratory congestion, and Cardilate for angina.

Cameron-Miller Surgical Instruments Co. — Booth 60

The Cameron-Miller Company booth, as usual, has something new this year. It is called a "Midget-Tome," and it is a real "compact." Although it is small enough to hang on the wall, it has all of the surgical modalities used in office or clinic. The price is also small. Actually it is a Giant, and has both "hot" and "cold" currents. All surgeons should also see the new safety items for the operating room—electrically lighted, electrically operated surgical instruments.

Carnrick Laboratories — Booth 49

Midrin for the treatment of migraine and tension headaches will be featured by Carnrick Laboratories. Midrin combines the cerebrovasoconstrictive action of isometheptene mucate with the relaxant-analygesic

effect of dichloraphenazone and Apap. The action of Midrin is similar to that of ergotamine tartrate, but without the toxic side effects often encountered with ergotamine therapy. For this reason, Midrin can be prescribed routinely in the treatment of vascular headache.

Ciba Pharmaceutical Company — Booth 22

This exhibit will enable the Ciba representative to discuss the importance of potassium in normal physiology, the clinical symptoms of potassium depletion—especially resulting from the administration of a diuretic—and a way to obviate this problem effectively and conveniently with Esidrix-K.

The Coca-Cola Company — Booth 44

Ice-cold Coca-Cola served through the courtesy and cooperation of the Coca-Cola Bottling Company of South Jersey, and The Coca-Cola Company.

Dome Chemicals, Inc. — Booth 56

Dome Chemicals Incorporated, world leader in dermatologicals, will feature dermatological specialties that are of general interest to the members of The Medical Society of New Jersey. Topical steroid products as Cort-Dome®, Neo-Cort-Dome®, Dome-form-HC™, Lida-Mantle-HC®, and Cor-Tar-Quin™ will be presented.

Our representatives will be available to discuss with you several products recently released from the research laboratories of Dome Chemicals.

The Doyle Pharmaceutical Company — Booth 33

Have you tasted Meritene? Meritene is the good-tasting Protein-Vitamin-Mineral food supplement prescribed to provide concentrated nutrition for patients with poor appetite or tolerance for ordinary food. Visit our booth and let us serve you a cool, refreshing Meritene Nourishment.

While there, review also our Dietene Reducing Plan, designed to get better cooperation from overweight patients. The Dietene Plan provides optimum nutrition and maximum satiety without the use of drugs.

Meritene and Dietene are advertised only to the medical profession.

Eaton Laboratories — Booth 28

Since 1939, Eaton Laboratories has pioneered in the development of the nitrofurans, many of which have been available as legend drugs to the profession. Basic and clinical research is continuing on these as well as other classes of compounds. In addition, Eaton Laboratories offers a variety of research and educational services for all phases of medicine. Our representatives welcome the opportunity to furnish you with complete information covering these services to you and the nitrofurans.

Thomas A. Edison Industries — Booth 36

Encyclopaedia Britannica, Inc. — Booth 11

Encyclopaedia Britannica welcomes delegates to the 1964 meeting of The Medical Society of New Jersey and invites them to examine the great new edition of Britannica.

Official delegates may now purchase this magnificent set at an exhibit offer only available at our convention exhibits. Visit Britannica's booth #11 for free descriptive literature.

Geigy Pharmaceuticals — Booth 31

The Geigy exhibit features important new therapeutic developments in the management of cardiovascular disease as well as current concepts in the control of inflammation, hypertension and edema, depression, obesity, and other disorders, which may be discussed with representatives in attendance.

Health Insurance Council — Coffee Lounge

Hospital Service Plan of New Jersey — Booth 4

Hospital Service Plan of New Jersey—the nation's pioneer Blue Cross Plan—provides more than 2,600,000 New Jersey subscribers with the finest in prepaid health care protection. Through the cooperation of nearly 250 contracting hospitals in New Jersey and adjacent states, Blue Cross makes available care and treatment—comprehensive service benefits, not cash indemnity—for subscribers. Today, Blue Cross is meeting subscriber benefits totalling more than $100 million annually.

International Pharmaceutical Corporation — Booth 7

Debrox® . . . for ear wax is a solution of 6.5% Carbamide (Urea) Peroxide in a special anhydrous glycerol vehicle. Debrox® was designed to save valuable office time and to spare patients the discomfort of excess instrumentation through its unique chemomechanical cleansing and debriding action;

Debrox ® softens and fragments excess and impacted ear wax, and eases its removal. Debrox ® is proved non-toxic and non-sensitizing.

Gly-Oxide ® liquid is a flavored solution of 10% Carbamide (Urea) Peroxide in specially prepared anhydrous glycerol. Gly-Oxide ® is antibacterial and antifungal, and exhibits a pronounced cleansing and debriding action which is especially valuable in topical treatment of stomatitis—gingivitis symptoms and other infections of the gums, mouth, and throat.

Johnson & Johnson — Booth 29

Johnson & Johnson will display the latest improvements in surgical dressings, as developed by the Johnson & Johnson Research Laboratories. Of special interest is SURGICEL Absorbable Hemostat, a major advance in the control of hemorrhage which does not depend upon the normal clotting mechanism. DERMICEL Surgical Tape, a newly-improved high strength special-purpose dressing tape for patients with unusual adhesive tape sensitivity, is an outstanding addition to the complete line of adhesive tape products. Other products designed for your office, hospital, or patient use are also displayed. You will find well-informed representatives pleased to discuss these products or provide information on any other items made available by the world's largest manufacturer of surgical dressings and baby products.

Kessler Associates, Inc. — Booth 20

Prosthetic and orthotic devices used in conjunction with rehabilitation equipment necessary for the disabled to achieve independence will be displayed; also, new technics of fitting hemiplegia, paraplegia, and post polios with weight bearing braces utilizing plastic sockets and laminated cuff supports. Certified prosthetists will be present to assist and detail all inquiries related to temporary prostheses and hydraulic and pneumatic devices. Information regarding special equipment for activities of daily living will be available.

Knoll Pharmaceutical Company — Booth 40

Dilaudid ampules, multiple dose vials, and soluble tablets for relief of pain—including severe types where other analgesics may fail; Dilaudid Cough Syrup for the cough that must be controlled. Oral Metrazol therapy, in which Metrazol, Nico-Metrazol, Vita-Metrazol tablets, and elixir are used in fatigue, geriatrics, and convalescent patients. Quadrinal tablets and Quadrinal suspension, a pleasant tasting liquid preparation for the asthma patient. Akineton, effective in treatment of extrapyramidal disturbances.

Lederle Laboratories — Booth 14

Members of The Medical Society of New Jersey and their guests will be most cordially welcomed at the Lederle booth. Our medical representatives, who have access to the world-wide Lederle research organization, are prepared to furnish information regarding Lederle products and your related medical questions.

Lemmon Pharmacal Company — Booth 19

Lemmon Pharmacal Company welcomes the opportunity to participate in the annual meeting of The Medical Society of New Jersey. Products of special interest include those for the management of asthma, obesity, and anxiety-depression states. Neothylline ® (dyphylline), a superior xanthine, is the first derivative of theophylline that is soluble, stable, and neutral. It has attained remarkable therapeutic success, since it retains all the desirable pharmacologic actions of its classic predecessor, aminophylline, while eliminating its major inherent disadvantages. Our professional service representatives will be available to answer questions and to present product information.

David Levinson, Medical Specialties — Booth 21

David Levinson, Medical Specialties will exhibit the famous Medcolator and Medco-Sonlator, for the office treatment of low back, shoulder, and myofascial pain syndromes. Also on display will be the Kinemometer, the most accurate test of Thyroid dysfunction; and the Achilleometer, a self-recording unit, employing the Achilles reflex test, which may be used with or without an electrocardiograph.

Eli Lilly and Company — Booth 15

McNeil Laboratories, Inc. — Booth 12

Members of The Medical Society of New Jersey are cordially invited to visit our booth, Mr. Jim MacMillan in charge. Products to be featured are: Butibel ®, Butisol Sodium ® butabarbital sodium, Parafon Forte ® and Tylenol ® acetaminophen.

Mead Johnson Laboratories — Booth 52

The Mead Johnson Laboratories' exhibit has been arranged to give you the optimum in quick service and product information. To make your visit productive, specially trained representatives will be on duty to tell you about their products.

Medical-Surgical Plan of New Jersey — Booth 3

Medical-Surgical Plan is dedicated to the proposition that the best approach by physicians and their patients to mutual economic problems is through a voluntary prepayment mechanism. The continuing success of the Plan has been made possible by the enthusiastic cooperation of New Jersey Blue Shield's 6,700 Participating Physicians, whose continued support of the concepts of providing prepaid medical-surgical services has been the cornerstone of the Plan's success in the past . . . and will lead to its continued progress in the future.

Medi-Kal Physicians and Hospital Supply Company — Booth 43

Medi-Kal is a brand new name this year, but it represents over 100 years of past service to the medical profession of the State of New Jersey. Medi-Kal is new by name only. It is the new corporation resulting from the recent merge of South Jersey Surgical Supply Company of Red Bank, Scharfenberger's of Elizabeth, and Cosmevo Surgical Supply of Paterson. It is our intention to continue—and even improve upon—the service that has brought about the success of these three companies over the past years.

At this meeting Medi-Kal is pleased to display the very latest in medical examining and treatment room furniture. Won't you stop at our booth and see the new modular furniture, and discuss with our representatives our free planning service?

Merck Sharp & Dohme — Booth 8

The theme of the Merck Sharp & Dohme exhibit is "Service To Medicine." One phase features the details of the Merck Sharp & Dohme Postgraduate Program. Another feature includes information on teaching films for use by the profession and, also, lay films that can be utilized to portray the story of medicine to the lay public. The exhibit is concluded with a display of finger-tip files on selected Merck Sharp & Dohme products.

Organon, Inc. — Booth 55

Of particular interest Organon will exhibit: Hexadrol® (Dexamethasone)—one of the newer corticosteroids, Deca-Durabolin® (nandrolone decanoate)—a long-acting anabolic agent. Our professional service representatives will welcome the opportunity to answer your questions concerning Hexadrol® (dexamethasone), Deca-Durabolin® (nandrolone decanoate), or any of our other preparations.

Ortho Pharmaceutical Company — Booth 41

On display will be the well-known products for the control of conception. Of special note will be Ortho-Novum Tablets, the oral product specifically designed for contraception. Also featured will be the new Delfen Vaginal Foam, the latest development of our research laboratories; and Delfen Foam couples clinically proved effectiveness with enthusiastic patient acceptance. Your visit and questions will be most welcome.

Pfizer Laboratories — Booth 62

The Pfizer Laboratories' display has been specifically arranged for your convenience and to give you the maximum in quick service and product information. To make your visit worthwhile, technically trained medical service representatives will be on hand to discuss with you the latest developments in Pfizer research.

Physicians' Planning Service Corp. — Booth 13

Physicians' Planning Service Corp. offers physicians the opportunity to buy life insurance with no premium payments for the first five years. This is done through a series of notes at 6 percent simple interest. The corporation is also making available to physicians a ninety-four page booklet entitled "Professional-Partnership Purchase Plans." This up-to-date book covers professional partnership buy and sell agreements, and covers evaluation problems, tax considerations, and the various types of purchase agreements.

Physicians Products Company, Inc. — Booth 65

Riker Laboratories, Inc. — Booth 50

Representatives of Riker Laboratories, Inc. will be glad to supply you with complete information concerning our products which are available to the medical profession. Please feel free to request answers to any questions you may have. We will be looking forward to your visiting our booth.

A. H. Robins Company, Inc. — Booth 48

Roche Laboratories — Booth 45

New VALIUM® (diazepam) is of use in dealing with tension states stemming from stressful circumstances or whenever somatic complaints are concomitants of emotional factors. It is useful in

psychoneurotic conditions manifested by tension, anxiety, fear, and fatigue. VALIUM (diazepam) may also be useful in the alleviation of muscle spasm and spasticity associated with cerebral palsy and athetosis, and aid in acute agitation due to alcohol withdrawal.

Sandoz Pharmaceuticals — Booth 42

Sandoz Pharmaceuticals will feature Mellaril, Sansert, Cafergot P-B, Fiorinal, and Fiorinal with codeine. Our representatives will gladly answer questions about these and other Sandoz products.

W. B. Saunders Company — Booth 34

New Saunders books since last year's meeting include: Bockus: *Gastroenterology, Vol. II;* Emmett: *Urography;* Gellis and Kagan: *Pediatric Therapy;* Pernkopf: *Color Atlas of Anatomy*; and *Current Therapy 1964.*

Schering Corporation — Booth 18

Schering Corporation welcomes the members of The Medical Society of New Jersey. Our representatives will be on hand to discuss with you the most recent advances in the Schering Allergy Relief Group.

G. D. Searle & Co. — Booth 1

You are cordially invited to visit the Searle booth, where our representatives will be happy to answer any questions regarding Searle Products of Research. Featured will be Enovid for ovulation control and pregnancy and menstrual disturbances; and Flagyl, a potent, new trichomonacidal agent for trichomonal vaginitis, cervicitis, urethritis, and prostatitis.

Smith Kline & French Laboratories — Booth 17

May we discuss the use of SK&F products in your specialty? Our representatives, Mr. W. J. McCabe and Mr. J. F. Lavin, are on duty to answer specific questions you may have. Also, information on SK&F's spectrum of services to medicine is available on request.

E. R. Squibb & Sons — Booth 30

William Allen Steadman & Company — Booth 47

William Allen Steadman & Company are the originators of complete financial service to the medical profession. This Company is the investment adviser and the underwriter for Steadman Investment Fund, Inc. It is also the underwriter for Professional Service, Inc. These companies were organized at the request of a group of New Jersey physicians in order to provide financial and investment assistance from internship through retirement. Physicians and their wives are cordially invited to visit the booth.

Stiefel Laboratories, Incorporated — Booth 59

Syntex Laboratories, Inc. — Booth 2

Norinyl® (Norethindrone 2.0 Mg with mestranol 0.1 mg) Tablets, an original steroid from Syntex Laboratories, will be features at Booth #2. Norinyl 2 mg supersedes artificial methods of contraception. Physicians are invited to register at the Syntex exhibit for complete information on this outstanding new product.

Booth 67

The Syntex exhibit will feature the successful topical steroid Synalar (fluocinolone acetonide), setting a new standard of success in the treatment of a wide range of dermatoses. Synalar is available in four forms:

Synalar Cream 0.025%

Synalar Ointment 0.025%—for initiation of therapy;

Synalar Cream 0.01%—for maintenance; and

Neo-Synalar—for treatment of infected dermatoses.

Synalar 0.025% and Neo-Synalar are available in 5 and 15 gm. tubes, and Synalar 0.01% is available in a 45 gm. tube. Synalar Ointment is available in 15 gm. tubes only.

Systemedics, Inc. — Booth 9

The services performed by this computer-based billing-accounting system, which has been specifically tailored for the professional practice, include the areas of recording, tracking, and summarizing all professional and financial activity in solo or partnership practices. The system is the result of an extensive development improving the methods of data transmission to the computer and increasing the variety and flexibility of results while eliminating expensive and/or complicated equipment and the need for removal of original records from the doctors' office. Both the economy and simplicity of the system are advantages to the doctor, and particularly so in the busy office requiring increasing labor and overhead expense to get the bills out and track delinquent accounts.

U. S. Vitamin and Pharmaceutical Corporation **Booth 53**

The Upjohn Company **Booth 68**

Wallace Laboratories **Booth 64**

The representatives of Wallace Laboratories will be glad to discuss the tranquilizer, Miltown, at booth #64. Miltown is proved for relieving both anxiety and muscle tension. Miltown is available in 200 mg. and 400 mg. dosage strengths and also as Meprospan, a 200 mg. and 400 mg. prolong release capsule, and Meprotabs, a 400 mg. coated tablet.

Warner-Chilcott Laboratories **Booth 61**

The products to be featured in our exhibit are: GELUSIL® and PAPASE®.

Warren-Teed Pharmaceuticals, Inc. **Booth 23**

You are cordially invited to visit the Warren-Teed exhibit. Featured product will be Modane®, a nutritional deconstipant for rehabilitation and relief of the atonic bowel. Our representative will welcome the opportunity to discuss this and other Warren-Teed specialties with you.

Westwood Pharmaceuticals **Booth 27**

Westwood invites physicians to stop by their booth to discuss their unique dermatological products: Fostex Cream, Fostex Cake, Lowila Emollient, Lowila Cake, Sebulex, Fostril, Alpha-Keri, Keri Lotion.

These products are particularly suitable for personal use by physicians and their families who may be plagued with dandruff, acne, dry and itchy skin, and sensitivities to soap. Register, so that we may send prescription units to your home.

White Laboratories, Inc. **Booth 24**

White Laboratories' exhibit features PERMITIL CHRONOTAB TABLETS (brand of repeat-action tablets of fluphenazine dihydrochloride). Medical service representatives will be happy to discuss the many indications for, and the superior therapeutic effectiveness of, this preparation.

ROOM RESERVATIONS

Complete and mail this form for your room reservation

198th ANNUAL MEETING—THE MEDICAL SOCIETY OF NEW JERSEY
May 16-20, 1964

Reservation Desk, Chalfonte-Haddon Hall, Atlantic City, New Jersey

Please reserve the following accommodations on the European Plan ( ) Modified American Plan ( )

No. of Rooms	ROOMS WITH BATH		HADDON HALL (Meeting Hdqts.)	CHALFONTE (Across Street)
	Single	For One Person	$ 9.00 ( ) $10.00 ( ) $12.00 ( )	$ 8.00 ( ) $ 9.00 ( ) $11.00 ( )
	Double (Twin Beds) without ocean view	For Two Persons	$14.00 ( ) $16.00 ( ) $17.00 ( )	$11.00 ( ) $13.00 ( )
	Double (Twin Beds) side ocean view	For Two Persons	$19.00 ( ) $21.00 ( ) $23.00 ( )	$16.00 ( ) $19.00 ( )
	Double (Twin Beds) ocean front	For Two Persons	$27.00 ( ) $30.00 ( )	$19.00 ( ) $21.00 ( ) $23.00 ( )
	Double Room and Parlor ocean front		$57.00 ( )	
	Double Room and Parlor side ocean view		$42.00 ( ) $44.00 ( )	
	Double Room and Parlor without ocean view		$34.00 ( )	

Each Additional Person in Double Room $4.00 European Plan or $11.50 Modified American Plan
Modified American Plan (Breakfast and Dinner) Add $7.50 per Day per Person

I will share a room with .....

Expect to arrive ..... Depart .....

Name .....

Address .....

This reservation will be acknowledged. Please arrange to double up when possible—single rooms are limited.

37th Annual Meeting
Woman's Auxiliary
to The Medical Society of New Jersey

CHALFONTE-HADDON HALL

ATLANTIC CITY, NEW JERSEY

May 17-19, 1964

Mrs. Samuel L. Kaman, Chairman

Mrs. Hugh Kearney, Co-chairman

Daily Schedule

Saturday, May 16, 1964

10:00 a.m. to 5:00 p.m.—Sale of Dinner-Dance tickets, MSNJ Registration Desk, Lounge floor, Haddon Hall

3:30 p.m.—Golden Merit Award Ceremony

Sunday, May 17, 1964

9:30 a.m. to 4:30 p.m.—Registration, Lobby floor, Haddon Hall

9:00 a.m. to 5:00 p.m.—Sale of Dinner-Dance tickets, MSNJ Registration Desk, Lounge floor, Haddon Hall

10:00 a.m. to 4:30 p.m.—Tickets on sale, Lobby floor, Haddon Hall, for:

Monday—Annual President's Luncheon (All doctors' wives invited)

Tuesday—Inaugural Luncheon

10:00 a.m.—Exhibits—Lobby floor, Haddon Hall: Art, County Press and Publicity Books, County Activities Pictorial Exhibit

11:00 a.m.—Pre-convention Board Meeting, Wedgwood II, Lounge floor, Haddon Hall

1:00 p.m.—Fellowettes' Luncheon, Navajo Room, 15th floor, Haddon Hall

3:30 p.m.—Tea and Fashion Show, Rutland Room, First floor, Haddon Hall

(All doctors' wives and guests are cordially invited to attend)

Monday, May 18, 1964

9:00 a.m. to 10:00 a.m.—Coffee and buns will be served, Room 134, First floor, Haddon Hall

9:00 a.m. to 4:30 p.m.—Registration, Lobby floor, Haddon Hall

9:00 a.m. to 4:30 p.m.—Tickets on sale, Lobby floor, Haddon Hall for:

Monday—Annual President's Luncheon (All doctors' wives invited)

Tuesday—Inaugural Luncheon

9:00 a.m. to 5:00 p.m.—Sale of Dinner-Dance tickets, MSNJ Registration Desk, Lounge floor, Haddon Hall

9:00 a.m.—General Session, Rutland Room, First floor, Haddon Hall

12:30 p.m.—Annual President's Luncheon, Carolina Room, Lounge floor, Chalfonte Hotel

3:30 p.m.—General Session reconvenes, Rutland Room, First floor, Haddon Hall

7:00 p.m.—Dinner-Dance, Carolina Room, Lounge floor, Chalfonte Hotel

Tuesday, May 19, 1964

9:00 a.m. to 10:00 a.m. Coffee and buns will be served, Wedgwood II, Lounge floor, Haddon Hall

9:00 a.m. to 1:00 p.m.—Registration, Lobby floor, Haddon Hall

10:30 a.m.—Post-convention Board meeting, Wedgwood II, Lounge floor, Haddon Hall

12:30 p.m.—Inaugural Luncheon, Rutland Room, First floor, Haddon Hall

LETTERS TO THE JOURNAL

Sir:

In the July JOURNAL, four pages were devoted to a transcript of a talk given by Miss Ayn Rand at the yearly dinner-dance of our society. Lest its thesis be accepted as the unanimous consensus of our membership, I ask the privilege of expressing my opposition to her philosophy. It would be offensive were I to express my distaste in as emotional a manner as did this authoress and editor of an "ultra-conservative" newsletter in behalf of utterly selfish conduct. I haven't the ability (in fact, I was taught otherwise) to use a string of adverbs and adjectives where one would suffice. I can't even distort the meaning of words to prove a point, but I can recognize a phony philosophy, a warping of semantics to establish non-existent premises.

I trust our members will read her essay carefully. By weighing her distortions and evaluating her thoughts they will better appreciate that opposition to her point of view, unfortunately shared by a few physicians of prominence, is neither socialistic nor un-American.

The very kernel of her thesis is that one who is altruistic is, *ipso facto,* a socialist; that altruism is a sin because it affirms that "service to others is the only moral justification for existence." If that be so, then let us indoctrinate our children to forsake the Judeo-Christian ethic. Let us invoke the ghost of Robert Louis Stevenson to take back the kind things he said about us. Let us forget that much of our education has been subsidized at the expense of communal and charitable funds. We must remember that "doctors are traders." We must? I won't.

No, Miss Rand, I don't buy your arguments. I and most of my fellow doctors think of ourselves as being altruistic, and we accept that epithet with pride. Not all of us will agree that "government controls . . . are (invariably) a stifling, deadening influence." Remember the S.E.C. and even the T.V. industry regulation commented upon unfairly in your next paragraph.

And as a self-appointed watch-dog of our treasury (without portfolio), may I protest having my dues pay for this type of propaganda?

GEORGE HELLER, M.D.
Englewood

Blood Bank Seminar

On May 9, at Voorhees Hall, Rutgers University, New Brunswick, a morning seminar on Blood Banking will be held. This will include a discussion on viral hepatitis and systems of preserving blood.

The program starts promptly at 9:30 a.m. and will terminate at 1:00 p.m. You are welcome.

Problem Drinkers

Readers sometimes want to know how to locate Alcoholics Anonymous. The New Jersey state address is 138 Clinton Avenue, Newark. A letter there will direct you to the office nearest your own area.

STATE ACTIVITIES

Trustees' Minutes

January 19, 1964

A regular meeting of the Board of Trustees was held at the Executive Offices on January 19. Following is a resume of the significant actions:

Expert Testimony . . . Received from the Administrative Director of the Courts announcement that the Supreme Court has extended the rule regarding impartial medical experts to cover the entire State, effective January 2, 1964.

Professional Corporations Act . . . Approved the action of Legal Counsel in authorizing a representative of the New Jersey Bar Association to state formally—at a hearing in Washington, D. C. on the proposed regulations concerning tax benefits available to professional people—"that the proposed regulations appear to be unfair to professional persons in their denial of equal tax rights currently available to employees of business corporations, and, in that regard, that the same would appear to discriminate unjustly against the professional person."

Mental Health Legislation . . . Directed that a communication be sent to the Commissioner of Institutions and Agencies, indicating the Society's interest and support in any steps he thinks necessary to bring about the revision of the mental health laws, in conformity with the Governor's declared intent in his second annual message to the Legislature.

Workshop on School Health . . . Approved the Society's co-sponsorship—with the State Departments of Health and Education—of a workshop program on smoking, pregnancy, venereal disease, and immunization to be held in East Brunswick on March 17.

AMA Mental Health Conference . . . Named Dr. Joseph R. Jehl, second vice-president, as the Society's representative to the AMA's Annual Conference of State Mental Health Representatives in Chicago on November 5, 6, and 7.

Medicare Fiscal Agent . . . Directed that ODMC be formally advised of the change to MSP as fiscal agent of MSNJ for the Medicare Program, for the contract year beginning July 1, 1964.

Membership Directory . . . Approved the following recommendations concerning the 1964-65 directory:

(1) Inclusion of a list of officers of MSNJ

(2) Publication of hospital staff personnel be retained

(3) Inclusion of advertising

(4) Appointment of Dr. George Sharbaugh, Chairman of the Publication Committee, as advisor on selection of advertisements

(5) Listings by counties and towns, rather than by town alone

(6) Approval of Composo-List as the compiler and publisher, on a three-year contract at no cost to the Society; publication of the *Membership Directory* to be on an annual basis, with the first issue in September 1964; the publisher to retain all income from advertising less commissions; each member to receive a copy of the directory, and 500 copies to be supplied to the Executive Offices; additional copies to be purchased by MSNJ at cost price; sale of directory by MSNJ with sales income to be retained by MSNJ.

Bicentennial History . . . Authorized the engagement of Mrs. Arlene R. Sayer of Trenton for preparation of the 1966 history of The Medical Society of New Jersey.

February 16, 1964

A regular meeting of the Board of Trustees was held on Sunday, February 16, 1964, at the Executive Offices. For information of the membership, detailed minutes are on file with the secretary of each component society. A summary of the significant actions follows:

Sabin Program . . . Received a letter from Governor Hughes, expressing appreciation to

MSNJ for their united efforts in the "Victory Over Poliomyelitis" campaign.

. . . Appointed Dr. Joseph R. Jehl of Clifton, Second Vice-President, to represent the President on a five-hour radio program (WNJR) for a discussion of the Sabin Oral Sunday Program.

JOURNAL *Advertisements* . . . Approved the action of the Executive Committee in agreeing that JOURNAL advertisement insertions of $50 or less no longer be required to be paid in advance.

Medical-Legal Conference . . . Authorized Legal Counsel (Robert M. Backes) and the Treasurer (Dr. Daniel F. Featherston) to attend the AMA Medico-Legal Conference in Chicago, April 16 to 18.

Battered Child . . . Approved the recommendation of the Special Committee on Child Health that MSNJ "cooperate with the State Youth Commission's Subcommittee on the Battered Child in its efforts to institute a survey to establish the prevalence of child abuse."

Maternal Deaths . . . Approved the recommendation of the Committee on Maternal and Infant Welfare that a comparative statistical study of maternal deaths in New Jersey (as reported by the Special Committee on Maternal and Infant Welfare of MSNJ and by the Bureau of Vital Statistics of the State Department of Health) be undertaken for publication by the Chairman of the Special Committee and the Chief of the Division of Maternal and Child Health of the State Department of Health.

Pap Smears . . . Approved the recommendation of the Cancer Control Committee that thorough and total systemic examinations for cancer detection in women be made by private physicians.

Annual Physical Examinations . . . Approved the recommendation of the Cancer Control Committee that MSNJ undertake an educational program—in conjunction with the State Department of Health, New Jersey Division of the American Cancer Society, the New Jersey Society of Pathologists, and other allied organizations—for annual physical health maintenance examinations, with special reference to cancer of accessible sites.

Cytologic Technologists . . . Concurred in the recommendation of the Cancer Control Committee that the State Department of Health match or exceed funds of the American Cancer Society (New Jersey Division) to train cytologic technologists who are in short supply; the Cancer Society proposed program to appropriate $15,000 to train 10 technologists.

Mammography . . . Concurred in the opinion of the Cancer Control Committee that, although the mammography technic is useful, it does not recommend mass survey methods because "accuracy is still a point of question; mammography is a study of a single part of the body; any examination should be total. We cannot segregate one part of the body and ignore the rest."

Medical Service Corporations . . . Rejected the Council on Legislation's recommendation of active opposition to S-94 and voted to approve this measure, on the basis of assurance given by MSP that S-94 is completely acceptable to them in all phases and provides adequate protection of the rights and interests of the Plan.

Hospital Service Corporations . . . Amended the Council on Legislation's position of disapproval of S-93 to one of approval, in view of its action on S-94.

Carbon Tetrachloride . . . Rejected the recommendation of the Council on Legislation to approve A-200—which prohibits as a disorderly person offense, the selling, offering for sale, buying, exchanging, possessing or giving away of any fire extinguisher containing a carbon tetrachloride—and adopted a position of no action.

Medical Practice Act . . . Approved the recommendation of the Council on Public Relations that copies of the most recent printing of the Medical Practice Act be made available to secretaries and executive secretaries of component societies, for use in their offices and for distribution to members who request them.

Golden Merit Award . . . Approved the recommendation of the Council on Public Relations

that the Golden Merit Award be granted to all candidates who are alive as of January 1 of the 50th year following attainment of their M.D. degrees. (If any member dies between January 1 and the date the award is made, the plaque will be sent to his family.)

Emergency Medical Call System . . . Approved the recommendation of the Council on Public Relations that the Board of Trustees send a letter to the State Board of Medical Examiners, and through this agency, inform the Attorney General that the system of emergency medical coverage throughout New Jersey has been reviewed and the Society would like to discuss with him methods of improving the service. . . . Approved the suggestion of the Council on Public Relations that a letter be sent to component societies, urging renewed interest in the emergency medical coverage system at county level.

Board of Medical Examiners . . . Sent the following nominations to Governor Hughes for terms of members of the State Board of Medical Examiners that would expire on March 13, with the order of preference indicated:

Incumbent— Luke A. Mulligan, M.D., Leonia
Candidates— 1. Luke A. Mulligan, M.D., Leonia
2. Thomas C. DeCecio, M.D., Cliffside Park
3. Charles Cunningham, M.D., Vineland.

Incumbent— John A. Kinczel, M.D., Trenton
Candidates— 1. John A. Kinczel, M.D., Trenton
2. Jerome G. Kaufman, M.D., Maplewood
3. Spencer T. Snedecor, M.D., Hackensack

Regional Planning . . . Named Dr. Jesse McCall of Newton, Dr. Louis S. Wegryn of Elizabeth, and Dr. Louis S. Albright of Spring Lake —without prejudice to MSNJ official sponsorship—for places on the Health Facilities Planning Council of New Jersey.

New Jersey Welfare Council . . . Designated Dr. John J. Bedrick of Bayonne to serve as the MSNJ delegate to the 1964 Annual Conference of the New Jersey Welfare Council in Newark on March 5.

MSP Board Nominations . . . Approved the nominations for membership on the Board of Trustees of MSP for three-year terms (1964-67) as submitted, as follows:

Joseph P. Donnelly, M.D., Obstetrics and Gynecology, Hudson County.
Joseph I. Echikson, M.D., Internal Medicine, Essex County.
Jerome G. Kaufman, M.D., Internal Medicine, Essex County.
Joseph M. Keating, M.D., Surgery, Passaic County.
Elton W. Lance., M.D., Surgery, Union County
Samuel J. Lloyd, M.D., Surgery, Mercer County.
Jesse McCall, M.D., Internal Medicine, Sussex County.

SHIPPING SPECIMENS TO HEALTH DEPARTMENT

When you send a specimen to the Health Department in Trenton and enclose some data, you make the whole package a "letter" subject to first class rates. In the future, the containers you receive from the State Health Department will be properly marked and the postage indicated. As for the containers you have on hand, you may:

(a) Return them to Trenton, unused, in a bulk package at parcel post rates. The State Health Department will then correct the labels and send them back. If you want to do this, send the parcel to Department of Health, Box 1540, Trenton, New Jersey 08625; or

(b) Write on each label "First Class Mail Enclosed" and then affix postage like this:

The small G.C. slide container	9c
The yellow labeled serology tube	11c
The blue labeled nose & throat tube	13c
The white labeled T.B. container	17c
The stool container to virology	17c
The blue labeled stool container	19c
The small and large water containers	38c

If you forget to write "First Class Mail Enclosed" and use the old containers, you are going to have to pay 5c per ounce for the whole package, which will make the cost about double. So, please cooperate!

RADIATION PROTECTION

Dr. Louis J. Levinson of Newark is our Society's representative to the Radiation Protection Commission. Here is Dr. Levinson's summary of the November 22, 1963 session.

Dr. Dunnington, chairman of the commission, recalled that, a year ago, a hearing was held on the proposed modifications of the codes which would permit an agreement with the Atomic Energy Commission to take over the licensing of certain radioactive materials. This has not been followed through, but a new proposed modification of the code dated October 11, 1963 proposes the following:

Instead of take-over and licensing of radioisotopes, it is suggested that we urge the licensing by the State Department of Health of naturally occurring radioactive materials at present not licensed by the Atomic Energy Commission. In hospital and office medical practice, this would pertain chiefly to radium and Radon. Under this plan, the present user of radioactive isotopic material would continue his license with the Atomic Energy Commission; but he would have to continue registration with the State. Thus all radioactive materials in the quantities above exempt limits (not controlled by the Atomic Energy Commission) would be licensed by the State. It was pointed out that under section 5.7 of the Code, the State Department would pass on the qualifications of those applying for a license to use radium or Radon.

Dr. Dunnington stated emphatically that, since the use of radium sources has not been previously licensed, it is time that something is done about it, because it is particularly dangerous if a leak develops in encapsulated sources of radium.

In the case of a hospital or physician renting a source of radium or Radon for medical use, the individual using this radium must also have a license—(see Section 5.1 of the Code).

It is recommended that the user of radium should post a proposed plan of procedure in case an encapsulated source develops a fracture or a leak which may endanger by contamination personnel exposed to such an incident.

The Fire Department in large cities and Civil Defense organizations in small communities should have cognizance of the location and quantity of radium in any organization using such material.

Physicians practicing mammography, or other low kilovoltage diagnostic technics, may make application to the State Department of Health to obtain an exemption from what appears to be a violation of Section 18.3.1.3 of Chapter II, special requirements, of the Radiation Protection Code. Mammography, a new technic under development by radiologists, is used for early detection of cancer of the breast.

Doctors using this are urged to apply to the Department immediately for an exemption, stating the purpose intended and including an estimate of the number of such examinations per month. If such procedures are conducted at hospitals or other institutions, the application should be made by the hospital or institution; and information covering the activities of all staff members should be included.

Applications for exemption should be mailed to Mr. William H. Aaroe, Radiologic Health Program, New Jersey State Dept. of Health, 17 West State Street, Trenton, N. J. (08608).

Violation occurs when added filtration is removed such that the total filtration permanently in the useful beam of medical radiographic units is less than 2.5 millimeters aluminum equivalent.

Physicians are cautioned about replacing the removed filtration prior to using the machine for normal diagnostic procedures.

NATIONAL GP SESSION IN NEW JERSEY

The Academy of General Practice is holding its scientific assembly this year in Atlantic City. The program begins on April 13 and runs for three days. The theme is "The Family Medical Perspective." All doctors, regardless of speciality, are welcome and can take something of value to their patients from this concentrated dose of medical learning in the tangy air of our Jersey shore.

The International System of Units

The Bureau of Standards of our Department of Commerce has now adopted the International System of Units—designated SI. The SI is based on the following units: the meter (m) as the unit of length; the kilogram (kg) for mass; the second (s) for time; the ampere (A) for electric current; the degree Kelvin (°K) for temperature; and the candela (cd) for luminous intensity. Here are the more commonly used units:

Quantity	*Unit*	*Symbol*	
Area	square meter	m^2	
Volume	cubic meter	m^3	
Frequency	hertz	Hz	(s^{-1})
Density	kilogram per cubic meter	kg/m^3	
Velocity	meter per second	m/s	
Angular velocity	radian per second	rad/s	
Acceleration	meter per sec. squared	m/s^2	
Angular acceleration	radian per sec. squared	rad/s^2	
Force	newton	N	$(kg \cdot m/s^2)$
Pressure	newton per sq. meter	N/m^2	
Kinematic viscosity	sq. meter per second	m^2/s	
Dynamic viscosity	newton-second per sq. meter	$N \cdot s/m^2$	
Work, energy, quantity of heat	joule	J	$(N \cdot m)$
Power	watt	W	(J/s)
Electric charge	coulomb	C	$(A \cdot s)$
Voltage, electromotive force	volt	V	(W/A)
Electric field strength	volt per meter	V/m	
Electric resistance	ohm	Ω	(V/A)
Electric capacitance	farad	F	$(A \cdot s/V)$
Magnetic flux	weber	Wb	$(V \cdot s)$
Inductance	henry	H	$(V \cdot s/A)$
Magnetic flux density	tesla	T	(Wb/m^2)
Magnetic field strength	ampere per meter	A/m	
Magnetomotive force	ampere	A	
Flux of light	lumen	lm	$(cd \cdot sr)$
Luminance	candela per sq. meter	cd/m^2	
Illumination	lux	lx	lm/m^2
Plane angle	radian	rad	
Solid angle	steradian	sr	

In the International System there is only one unit for each quantity. Submultiples of each unit may be designated by the prefixes below listed.

Thus, an illumination of 100 luxes would be a hectolux, while an illumination of a millionth of a lux would be a nanolux. A million henries of inductance would, similarly, be a gigahenry.

Multiples and Submultiples	*Prefixes*	*Symbols*
10^{12}	tera	T
10^9	giga	G
10^6	mega	M
10^3	kilo	k
10^2	hecto	h
10	deka	da
10^{-1}	deci	d
10^{-2}	centi	c
10^{-3}	milli	m
10^{-6}	micro	μ
10^{-9}	nano	n
10^{-12}	pico	p
10^{-15}	femto	f
10^{-18}	atto	a

If you do not bind your JOURNALS, you might want to cut this material out and mount it on a card. This tabulation is not readily found elsewhere.

OBITUARIES

Dr. Fred Finn

One of America's pioneers in radiology, Dr. Fred A. Finn, died on January 31, 1964. Fred Finn was born in 1878, and was a 1903 graduate of the College of Physicians and Surgeons of Columbia University. He had served his community in a variety of ways: police surgeon, rehabilitation commissioner, member of Board of Health, compensation examiner, and hospital staff work. He was a charter member of the American Roentgen Ray Society and was one of the first doctors in the United States to make this his specialty. He remained in active practice until 1960, and when he retired he was the oldest medical practitioner in Hudson County. In 1957 he was the laureate of a Golden Merit Award from The Medical Society of New Jersey.

Dr. George F. Hilker

Dr. George F. Hilker, one of Middlesex County's leading citizens, died unexpectedly on January 28, 1964 at the Perth Amboy General Hospital where, until recently, he had been president of the medical staff. Receiving his M.D. from Cornell in 1930, Dr. Hilker opened his office in the fall of 1931 in his native Perth Amboy. He was a general practitioner with special interest in anesthesiology, and was, for many years, an anesthesiologist at the Perth Amboy General Hospital. He also served a term as director of anesthesia there. He was one of the founders, and an early president, of the Raritan Bay Academy of Medicine and was active in the International Society for Research in Anesthesiology. Dr. Hilker was only 59 at the time of his death.

Dr. Lee W. Hughes

One of New Jersey's veteran ophthalmologists, Dr. Lee Westlake Hughes, died on January 25, 1964 at the age of 71. Born in Tioga, Pennsylvania, he had a brief period as a school teacher, and then entered the Jefferson Medical College. Receiving his M.D. degree in 1916, he did graduate work in ophthalmology at the Wills Eye Hospital in Philadelphia and in 1922 was certified by the American Board of Ophthalmology—one of the first New Jersey physicians to be so certified. (This Board was established in 1918.) In that year, he opened his office in downtown Newark for the private practice of his specialty, and for thirty years served the people of that area. In 1956 he moved his office to South Orange. Dr. Hughes was a chief of ophthalmology or a consultant in that field at Clara Maas, St. Barnabas, St. James, St. Claire's, East Orange General, St. Vincent's, Presbyterian, and West Hudson Hospitals. For many years, he was one of the senior ophthalmic surgeons at the Eye and Ear Infirmary in Newark. He was an FACS and a past-president of the New Jersey Society of Surgeons. He was prominent in child development studies in ophthalmology, and was an ophthalmic consultant to the Bucks County (Penna.) Child Development Center.

Dr. Harriet L. Knox

At the grand old age of 91, Harriet L. Knox died on December 2, 1963. Rutherford B. Hayes was inaugurated as President of the United States on the day she was born. She received her M.D. at Women's Medical College in 1894 (during the administration of Grover Cleveland) and had an interneship at the New York Infirmary in the days when interneships were unusual and women physicians were rarities. During the Spanish-American War she tried to enlist in the Army's Medical Corps—or the Navy's—but was rejected on the grounds that women could not be commissioned in the military. So she changed uniforms and served as a nurse! Returning from this service late in 1898, she went into private practice in Hackensack, and there she remained for the rest of her long life. She was a general practitioner, interested in family practice, doing pediatrics, obstetrics, and all phases of general medicine. From 1899 to 1907 she made her rounds on horse-back. Then she bought a buggy. But a year later, always a devotee of living dangerously, she bought an automobile—possibly the first woman in Bergen County to drive one of those uncertain contraptions. She lived to become a much beloved institution in northern New Jersey and the model of the family doctor.

BOOK REVIEWS

Primer of Clinical Measurement of Blood Pressure. By G. E. Burch, M.D. and N. P. De Pasquale, M.D. St. Louis, 1962, Mosby. Pp. 141. 51 figures and 9 tables. ($5.50)

"No data are better than wrong data" is the closing comment in this book devoted primarily to accurate blood pressure measurement. A brief historic review is followed by a short reference to physiology of arterial blood pressure. Technics of measurement, apparatus, sources of error, and factors affecting blood pressure are then detailed. A chapter on normal values includes data from a number of large studies, showing ranges of normality at different age levels for males and females. The difficulties in defining normal arterial blood pressure are discussed. Some of the diagnostic applications of blood pressure measurements are also presented.

The language of the text is simple and concise. A medical student will find it a useful supplement to what he has learned about the blood pressure in physiology and clinical medicine. A physician interested in blood pressure measurement will benefit from this extensive bibliography. This volume would be a real asset on a library shelf in a school of nursing, to be used as a reference by those so often entrusted with blood pressure measuring in clinical practice.

Although the authors mention some of the important diagnostic applications of arterial blood pressure measurements, a definition of hypertension is avoided. A brief discussion of this would have added to the completeness of this monograph.

Katherine Hiduchenko, M.D.

Medical Resident's Manual. By Frank B. Flood, Richard J. Kennedy, and William J. Grace. Paperback. New York, 1962, Meredith Publishing Company. Pp. 311. ($4.95)

This 300-page manual is a pocket-sized compendium of medical conditions most likely to be encountered during a medical residency. It includes brief and tabulated descriptions, criteria for diagnosis, laboratory procedures, and in certain instances, treatment suggestions. There are the usual tables of normal values. The subject material is presented in alphabetical order from Addisons Disease to Zollinger-Ellison Syndrome. This makes it unnecessary to resort to an index.

More than 40 pages are devoted to the electrocardiogram and derived vector analysis. This is the single major section of the book and the sort of thing not usually found in this type of manual. One might argue that there is a disproportionate emphasis on the subject; on the other hand, it can serve as a guide reference for the resident not yet completely oriented.

The authors state in the preface that their book is an out-growth of the residents' loose-leaf pocket notebook in which he has written his daily notes and newly discovered "pearl" for future reference. Of course, not all the pearls could possibly be contained in a brief manual, and the resident had better be advised not to discard his loose-leaf pocket notebook. In spite of its short-comings, he will find this book useful. Harvey E. Nussbaum, M.D.

Peripheral Vascular Diseases. Ed. 3. By Edgar V. Allen, M.D.; Nelson W. Barker, M.D.; and Edgar A. Hines, Jr., M.D. Philadelphia, 1962, Saunders. Pp. 1044. 367 illustrations. ($18.00)

This edition is an excellent text for the medical student as well as a reference book for the practitioner and the peripheral vascular disease specialist. The current volume is a great im-

provement over the two previous editions. The first edition was a commendable pioneer effort, but with this rapidly expanding field of medical science, many subjects have been included in this edition, which were not present in the earlier editions. Included now are the newer concepts of arterial diseases, blood coagulants, fibrinolysis, and angiography. The therapy of the viceral aneurysms and extra cranial and cerebral occlusions have been adequately described, discussed, and illustrated.

The description of peripheral vascular diseases as of now, is so extensive that it cannot be presented by any single author. The present edition is the combined effort of twenty-six staff members of the Mayo Clinic. Also improved is the format, the print, illustrations and arteriograms, as well as the distribution and discussions of subject matter.

Jacob Schmukler, M.D.

Doctor and Patient and The Law. C. J. Stetler, LL.B and Alan Moritz, M.D. Ed. 4, St. Louis, 1962, Mosby. Pp. 529. ($14.75)

Essentially, this is a monograph on medical jurisprudence rather than on legal medicine. That is, it is a text on law and legal procedure, not a book on such medical problems as determining cause of death or estimating extent of disability. It is a compact, yet almost encyclopedic, volume. It includes material on adoptions, abortions, eugenic sterilization, and artificial insemination. There are chapters on malpractice, medical fees, medical testimony, privileged communication, and similar problems in the whole area of jurisprudence. Several sample consent forms are included. An ingenious self-test for appraising your vulnerability to malpractice litigation is appended. The volume may be considered somewhat overpriced at $14.75, but it is a good solid text that will well earn its self-space in any physician's office. This book is the successor to Dr. Louis J. Reagan's standard work first published in 1943 and now brought thoroughly up to date.

Ulysses M. Frank, M.D.

Wound Ballistics. By Major James C. Beyer, MC, Editor. Washington, D. C., 1962, Department of the Army. Pp. 883. Illustrated.

Published under the direction of the Surgeon General, United States Army, this is one of the professional documents prepared by the United States Army Medical Service. It reveals for the first time the complete details of the medical studies in wound ballistics and body armor during World War II supplemented by the Korean War experience. It is intended for the training of the physician who may be treating the wounds of war. It is also useful as a guide for the ballistic engineers in other technical services engaged in personnel armor design and evaluation. The volume is very detailed and not easily read, but there is a wealth of illustration accompanying the text. This book will give the physician much valuable knowledge of the weapons and missiles which create the wounds and of the wound track characteristics of these agents. If he learns his lesson well, his clinical decision as to treatment necessary will not be shortsighted and result in unwarranted errors. If studied thoroughly, the contents of this book should dispell the ignorance which leads to error. This is the real purpose of the study.

Eugene A. White, M.D.

Consumers Union Report on Family Planning. (paper) Edited by Alan F. Guttmacher, M.D. Published by Consumers Union, 1962, Mt. Vernon, N. Y. Pp. 146. ($1.75)

Technics of contraception and methods of improving fertility are explained in lay terms in this 146-page booklet. Most of the book concerns contraception, as only 32 pages are in the section in improving fertility. All the better known contraceptive methods are described and appraised; brand names and prices are mentioned. Readers are repeatedly advised to consult physicians before embarking on any contraceptive regime.

Henry A. Davidson, M.D.

ABSTRACTS

ON TUBERCULOSIS AND OTHER RESPIRATORY DISEASES. ISSUED BY THE NATIONAL TUBERCULOSIS ASSOCIATION

APRIL, 1964 • VOL. XXXVII, NO. 4

VALUE OF CLINICAL AND LABORATORY FINDINGS IN CRYPTOCOCCAL MENINGITIS

The prognosis for cryptococcal meningitis has greatly improved since the introduction of amphotericin B. Definitive diagnosis depends upon isolation and identification of C. neoformans. The clinician must have a high index of suspicion in any case of meningitis.

Before the introduction of amphotericin B in 1956, three quarters of the patients with cryptococcal meningitis died during the first year of illness.

In the present report the course of the disease in 40 patients studied at the Clinical Center of the National Institutes of Health during the years 1956-62 are reviewed. Of the 40 patients, 36 received amphotericin B.

Diagnosis

Prior to the diagnosis, headache was the most frequent symptom of which the patients complained. It was described as mild to severe, occasional to continuous, dull to sharply painful, and gradual to sudden in onset. Mental changes were the next most common complaint and included confusion, personality changes, defects in memory, agitation, and psychosis. Visual abnormalities occurred in two-fifths of the patients.

In 6 patients, symptoms referable to the central nervous system either were absent or, if present, did not lead directly to a diagnosis of meningitis.

In 39 patients lumbar puncture and examination of the cerebrospinal fluid were performed before diagnosis and treatment. In all but one case the cell count was abnormally high, and in all but four the protein value was elevated. The opening pressure was above the normal limit in 64 per cent whereas the sugar value was below normal in only 55 per cent of the patients.

Differential cell counts were available in 35 patients and revealed predominately a lymphocytic response. Yeastlike forms were seen on direct examination of the cerebrospinal fluid in 20 of the 35 patients studied.

Cultures Positive

Cerebrospinal-fluid culture was positive for *C. neoformans* in 38 of the 40 patients. Culture of specimens other than cerebrospinal fluid was performed in 34 cases, and in 20 (59 per cent) of these, at least one specimen was positive for *C. neoformans*. Urine was positive in 37 per cent of patients tested.

Of the 40 patients in the study, 36 received amphotericin B. Thirty-one of the treated patients improved and five, all of whom had coexisting disease, died of progressive meningitis or disseminated cryptococcosis. Deaths due to progressive meningitis usually occurred early in the course of treatment. The four untreated patients also died.

As of January 1, 1963, 17 of the 31 patients who had improved remained well, three had died of causes unrelated to cryptococcosis, and

WILLIAM T. BUTLER, M.D.; DAVID W. ALLING, M.D.; ANDERSON SPICKARD, M.D.; and JOHN P. UTZ, M.D., *The New England Journal of Medicine*, January 9, 1964.

the remaining 11 had had one or more relapses of meningitis. All of the relapses occurred within one year of the end of treatment.

Drug Administration Routes

It was the practice of the authors to administer amphotericin B to the more seriously ill patient by both the intravenous and intrathecal routes and to the less seriously ill by the intravenous route alone. With this choice of treatment three of the 12 patients (25 per cent) who received the drug by both routes died of progressive meningitis as compared to two of the 24 (8 per cent) treated by the intravenous route alone. However, of the patients who improved, relapse tended to be less frequent among those who received the drug by both routes than among those who received it by the intravenous route alone. The difference in relapse rates between the two groups was not significant, however, and comparability of the two groups was not provided for by prior planning in the allocation of treatment. It appears desirable to undertake a clinical trial to assess the value of intrathecal therapy. Patients treated by the intrathecal route invariably had an initial rise in the cerebrospinal protein value, which later fell.

In the five patients who died despite therapy the cerebrospinal-fluid sugar value improved, but not the values for pressure, cells, and protein. In the treated patients who survived, there was generally a prompt and sustained improvement in all values during treatment. After treatment, improvement continued but at a slower pace in those who did not relapse.

Relapse

Of the 31 patients who improved during the original course of treatment, 24 have been observed for at least a year since the end of initial therapy. Of these, 11 (46 per cent) have had a relapse. Relapse could not be related to the duration of illness before treatment, nor could it be related to the dosage of drug given or to the presence of coexisting disease.

The proportion of relapses was significantly greater among patients with initial protein values less than 100 milligrams per 100 milliliters than among those with values above 100 mg.

Coexisting disease occurred in 20 of the 40 patients. The diseases were diabetes mellitus, Hodgkin's disease, sarcoidosis, myeloid metaplasia, silicosis, and carcinoma of the breast. Relapse of meningitis was not more frequent in patients with coexisting disease than in those without. However, patients with coexisting disease often did poorly during initial treatment.

Comment

Follow-up data demonstrate that amphotericin B is reasonably effective not only in averting death in cryptococcal meningitis but also in restoring health. However, apparent recovery may be followed by a recurrence of illness and this sequence may be repeated two, three, or even four times.

Consideration of the chemotherapeutic requirements in other relapsing infectious diseases suggests such possibilities for improvement as longer periods of treatment and use of other chemotherapeutic agents with amphotericin B.

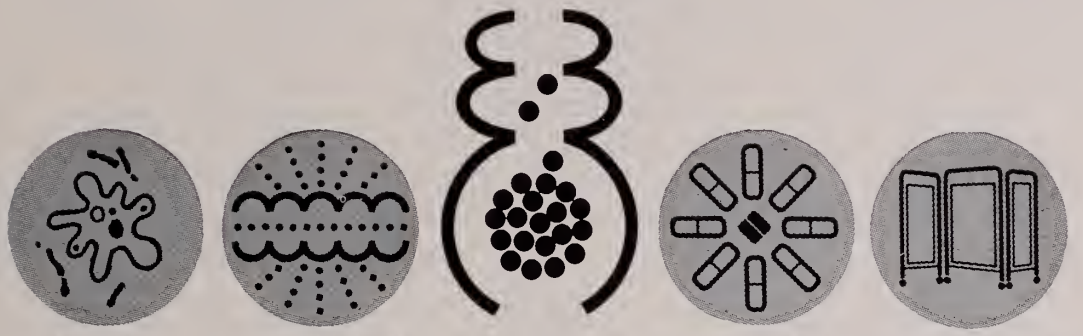
At present, neither of these possibilities appears to hold promise. In a previous study, larger doses of the drug were found not to decrease the likelihood of relapse. And combined therapy is precluded by the lack of an agent other than amphotericin B that is effective in the treatment of cryptococcal meningitis.

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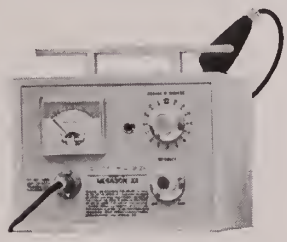
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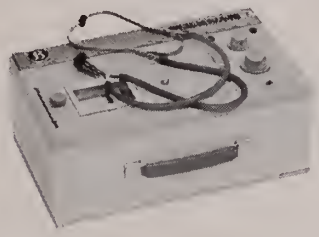
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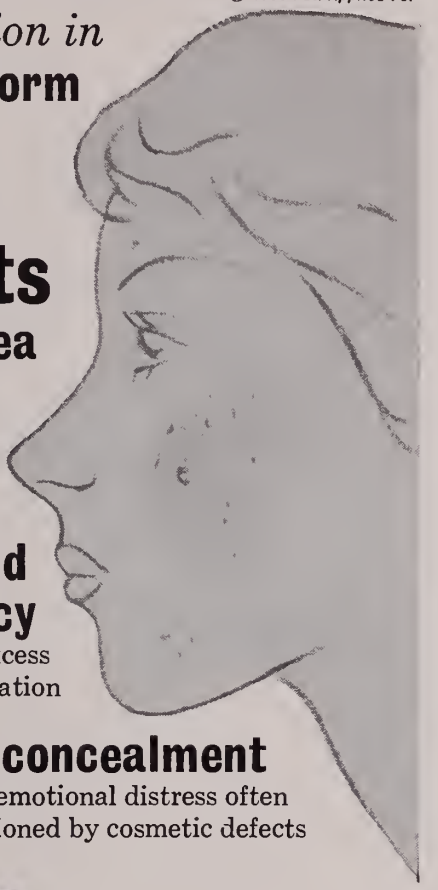
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1. Berger, R. A.: Clinical Medicine, Sept. 1961.

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MAY, 1964

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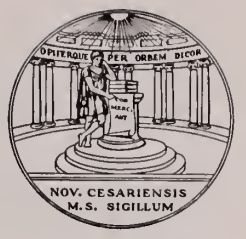
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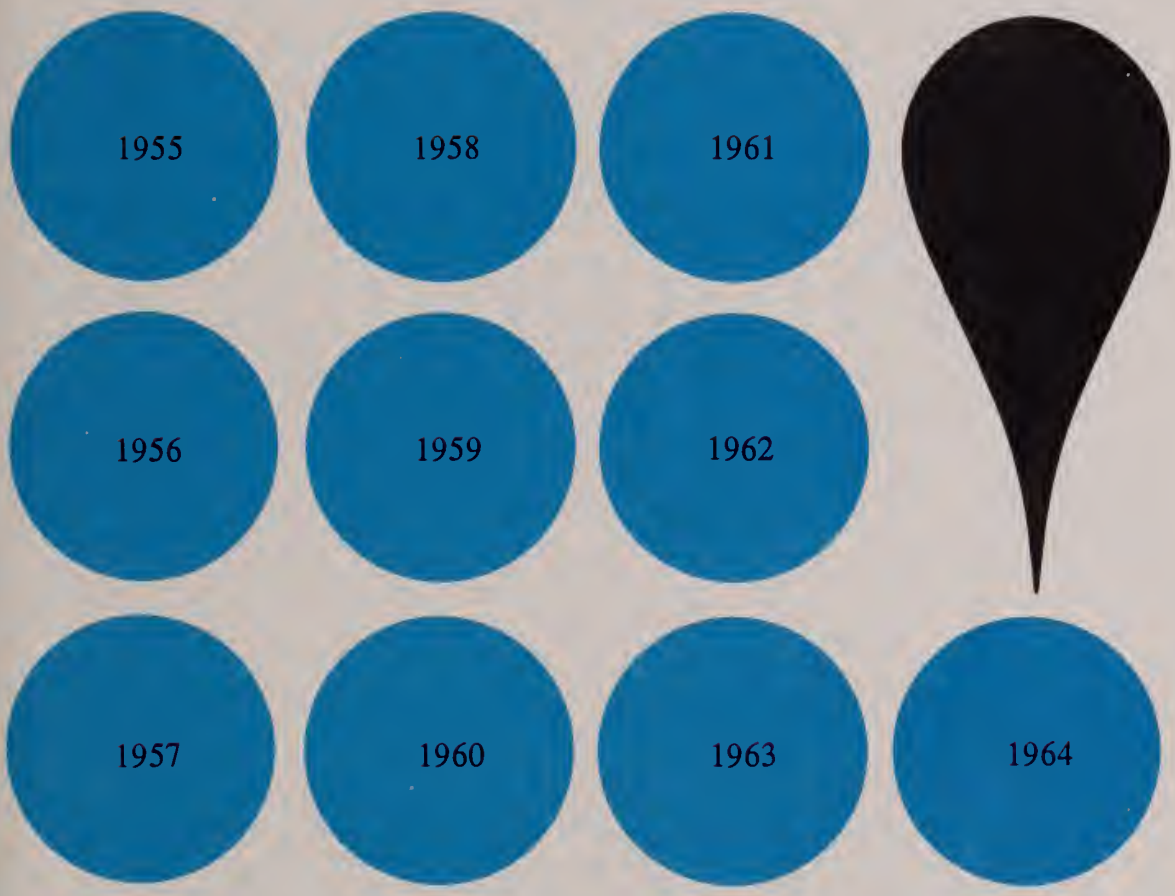
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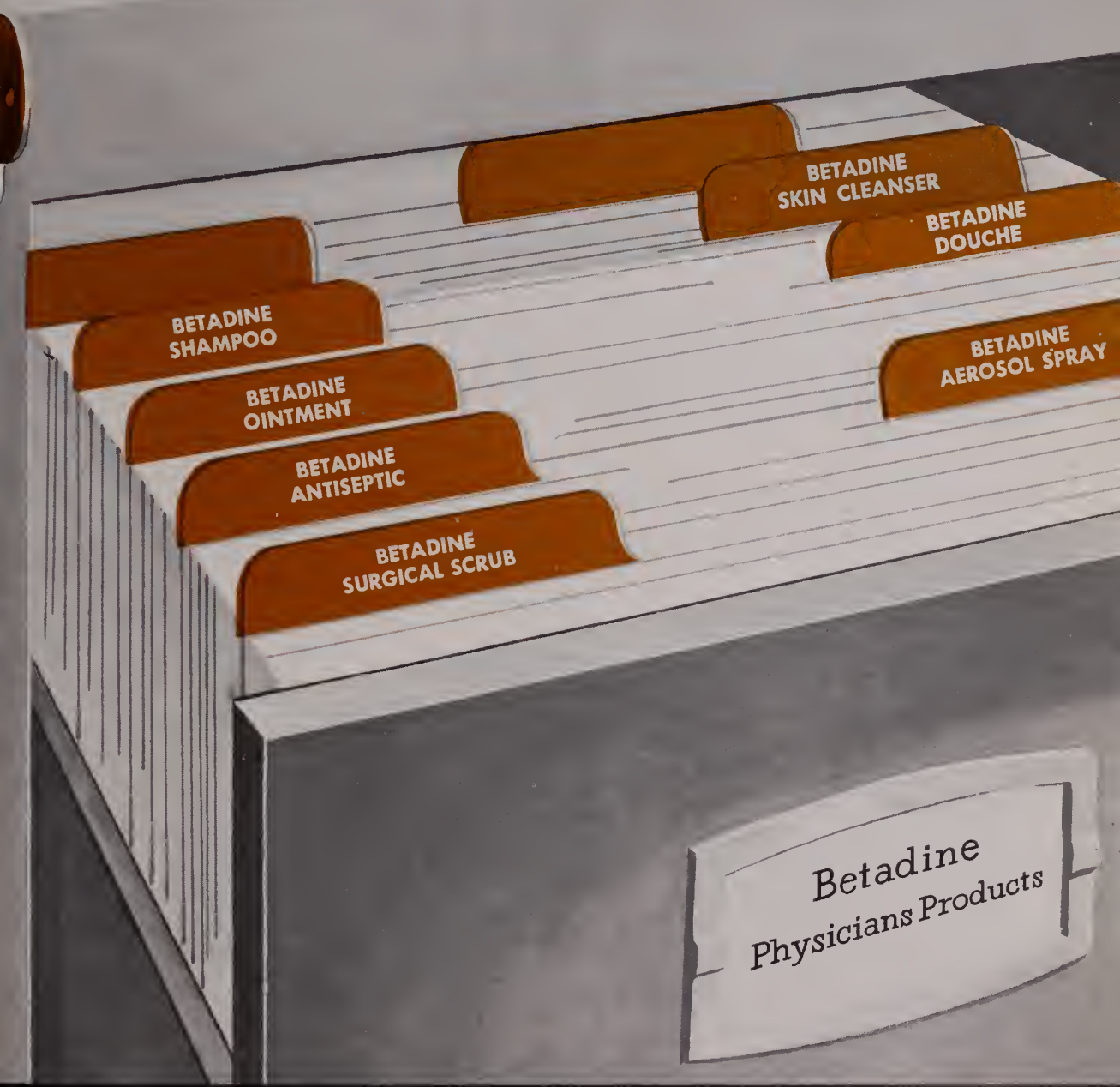
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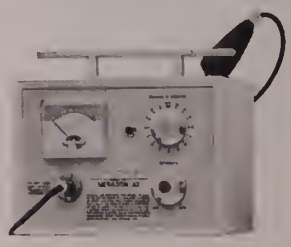
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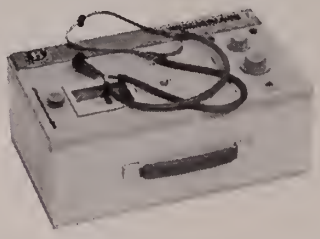
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Summary: Indicated in stable adult diabetes, sulfonylurea failures and unstable diabetes. Gastrointestinal side effects occurring more often at higher dosage levels abate promptly upon dosage reduction or temporary withdrawal. Occasionally an insulin-dependent patient will show "starvation" ketosis (acetonuria without hyperglycemia) which must be differentiated from "insulin-lack" ketosis, and treated accordingly. Use with caution in severe liver disease. Not recommended without insulin in acute complications (acidosis, coma, infections, gangrene, surgery). Consult product brochure for full information.

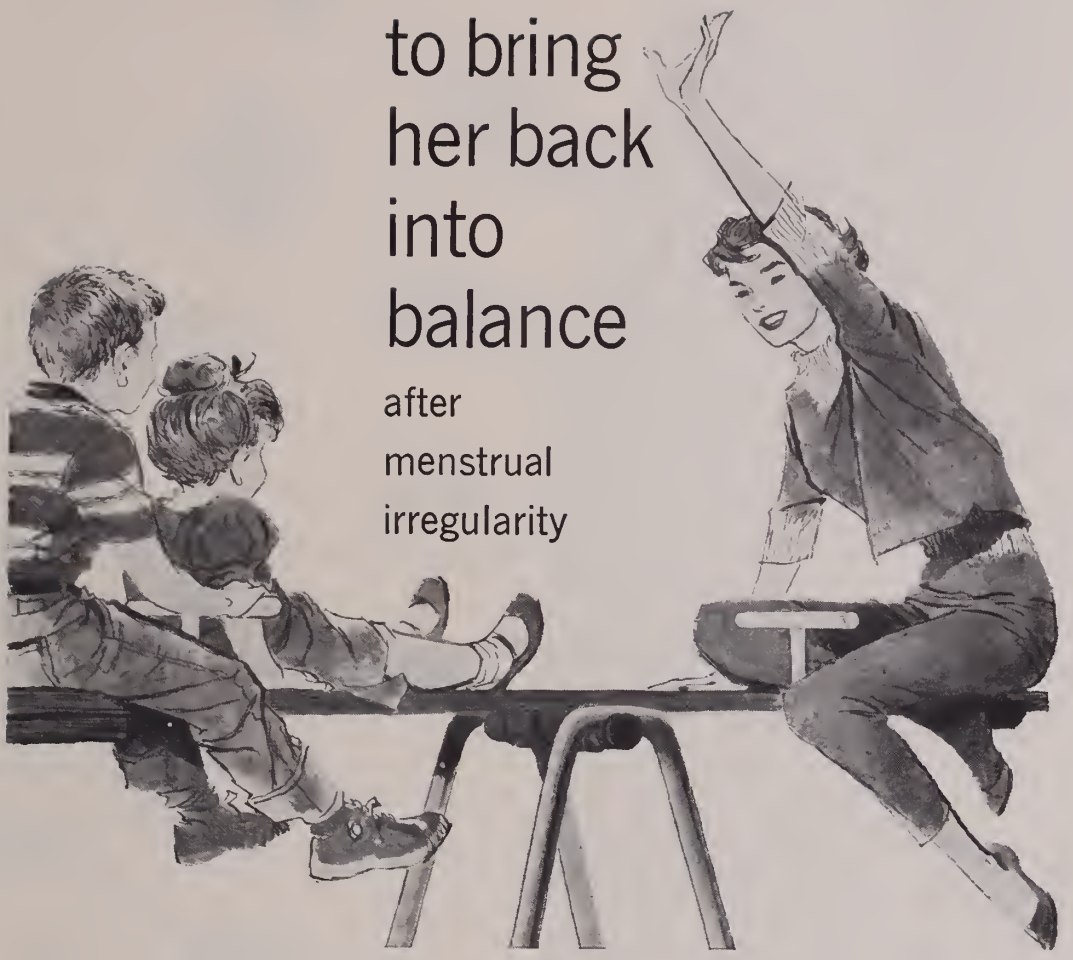
Bibliography: 1. Williams, R. H.: Textbook of Endocrinology, Ed. 3, Saunders, Philadelphia, 1962, p. 610. 2. Gordon, E. S.: Metabolism 11:819, 1962. 3. Grodsky, G. M. et al.: Metabolism 12:278, 1963. 4. Sadow, H. S.: Metabolism 12:333, 1963. 5. West, K. M. and Tophoj, E.: Metabolism 10:689, 1961. 6. Yalow, R. S. and Berson, S. A.: Diabetes 9:254, 1960. 7. Weller, C. et al.: Scientific Exhibit, A.M.A., June 1962. 8. Weller, C. et al.: Metabolism 11:1134, 1962. 9. Radding, R. S. et al.: Metabolism 11:404, 1962.

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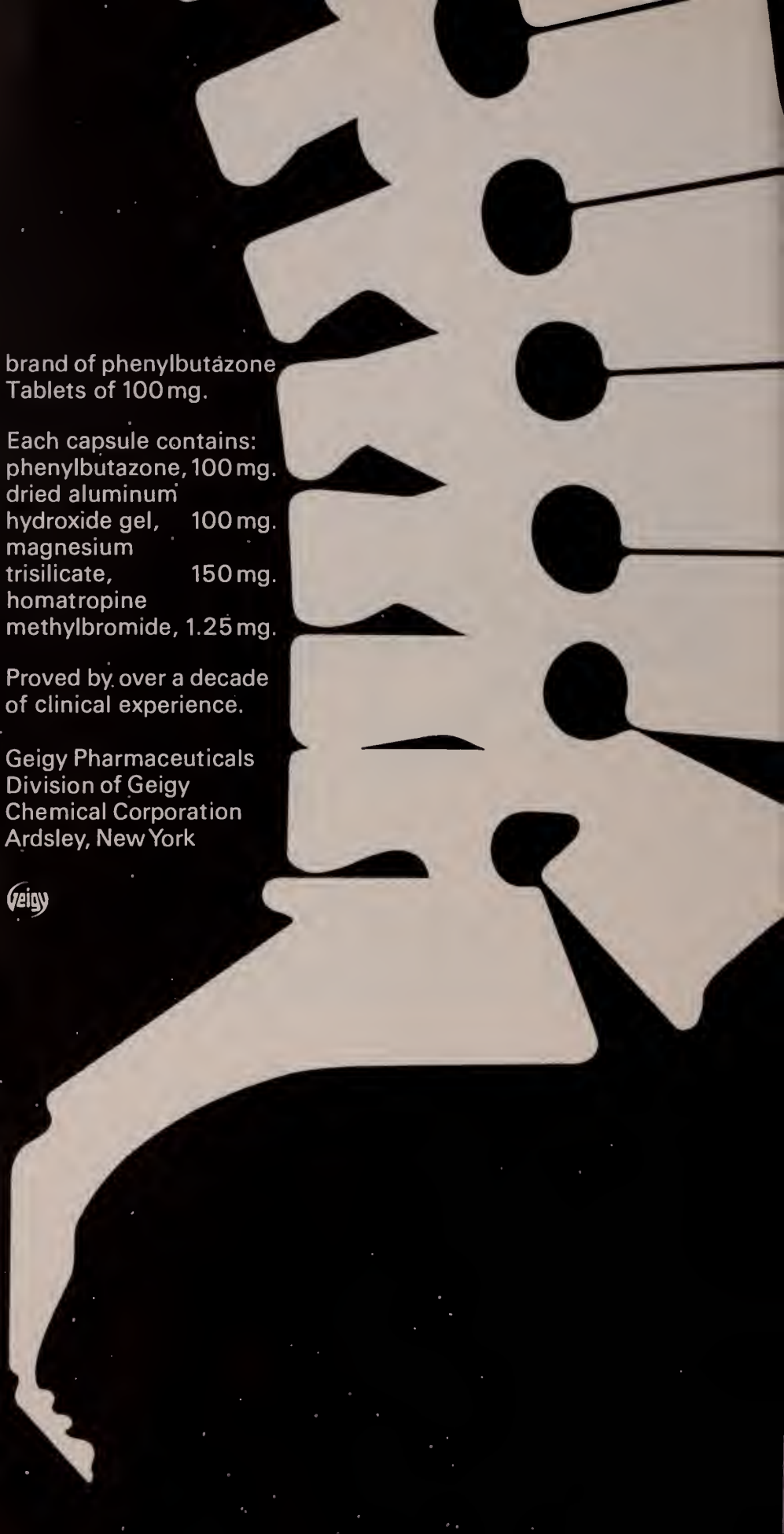
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* AMA Council on Foods and Nutrition: The Regulation of Dietary Fat, *JAMA* 181:411-423 (August 4, 1962).
AMA Council on Foods and Nutrition: Composition of Certain Margarines, *JAMA* 179:719 (March 3, 1962).

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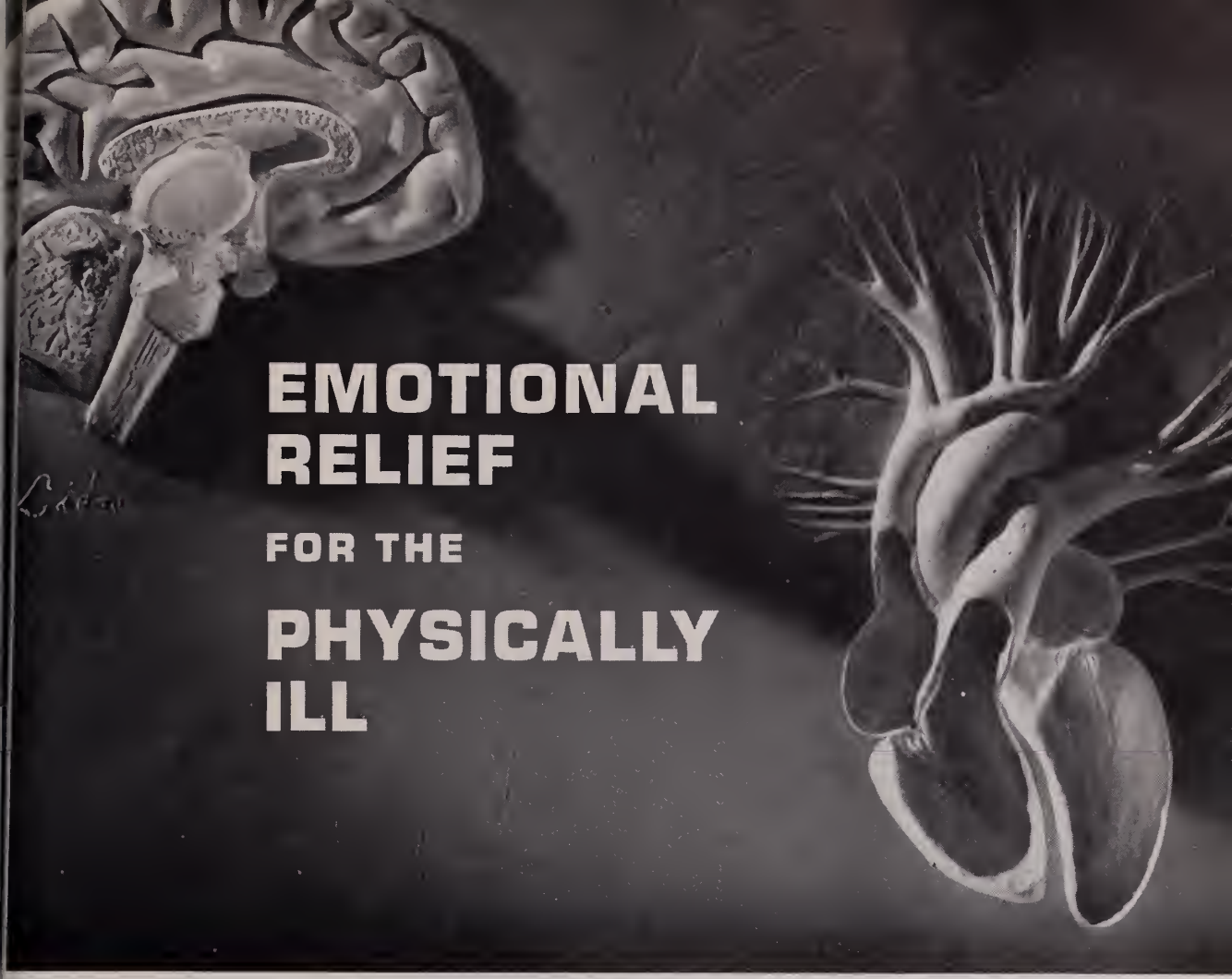
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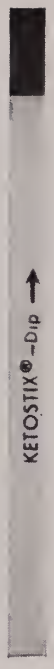
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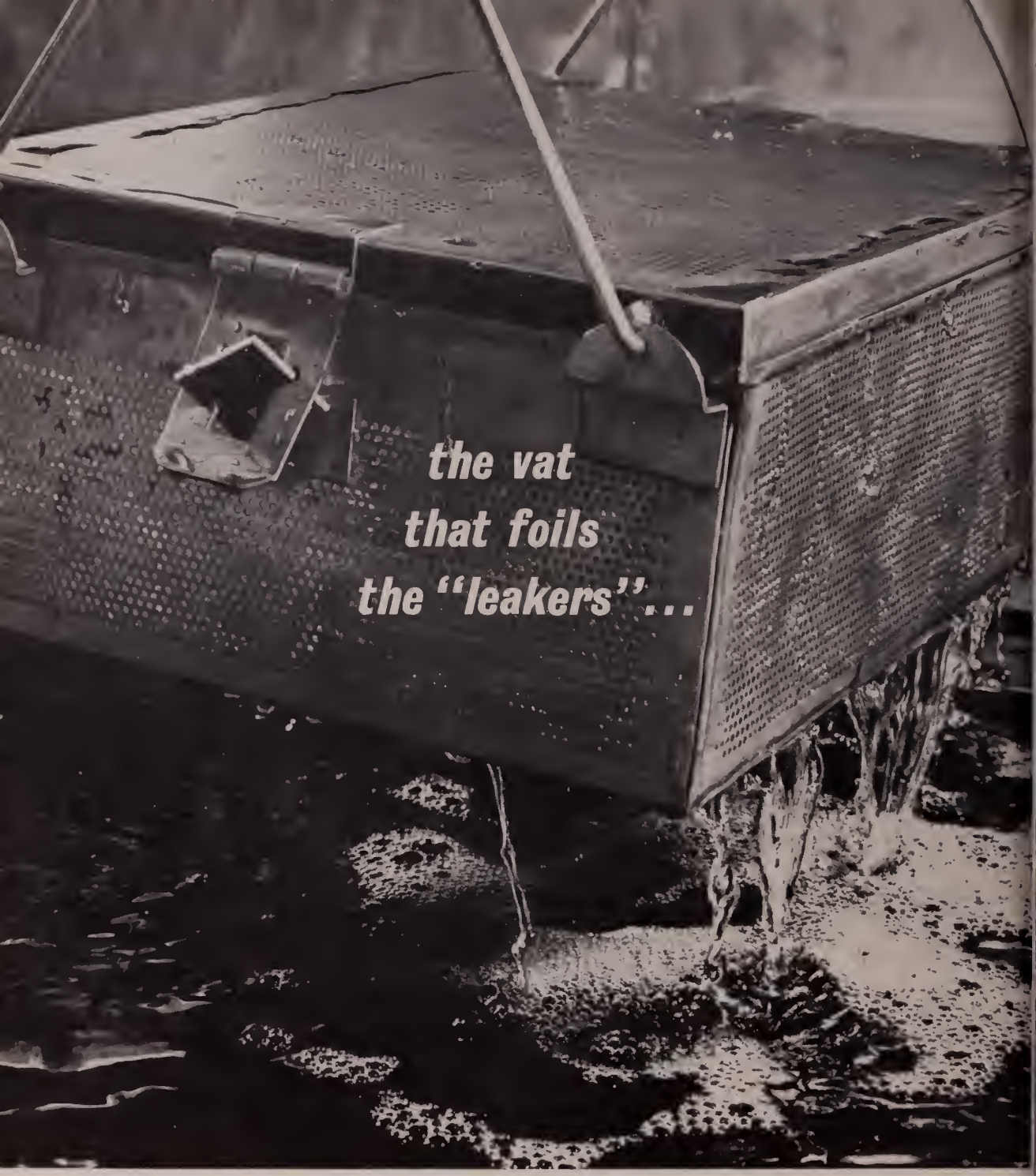




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EDITORIALS

Royal A. Schaaf 1892-1964

It is sometimes said that the medical profession does not produce great civic leaders the way it did a century or more ago. But if anyone asked us, in these past decades, to point to a truly great civic leader in our profession, we had a simple answer: look at Royal Schaaf.

When he returned from military service in 1919, he came to Newark where his uncle, Edward O. Schaaf, had considerable prominence as a musician and composer as well as a doctor. And from 1919 until his retirement to Hunterdon County in 1957, Royal Schaaf centered his medical activities in Newark. Throughout an extraordinary career of community service, he collected organizational presidencies and civic awards with, apparently, the greatest of ease. We know him, of course, as President of The Medical Society of New Jersey in 1947-1948. But he was also President of the Society of Surgeons, the Academy of Medicine, the Blue Shield Plan, the State Board of Medical Examiners, and many other organizations. Only two years ago, his medical alma mater honored him as "Mr. NYU Alumnus." He was an early laureate of the covetted Edward J. Ill Award. The American Cancer Society credited Dr. Schaaf with being largely responsible for the rapid growth of their New Jersey chapter. Rutgers University conferred an honorary degree on him in 1956, and Bloomfield College in 1957.

To most of us, his major service was probably in the expansion of voluntary health insurance in our State. While others were content to be *against* compulsory plans, Royal Schaaf wanted to be *for* something. At the start, only a handful of New Jersey doctors were vigorous in promoting Medical-Surgical Plan. Royal Schaaf was one of their leaders. In one way or another, he nursed and nurtured Blue Shield. His vigorous, but always courteous, defense of Medical-Surgical Plan became a feature of our annual meeting every May. Always, on that afternoon, it was open season on Blue Shield. The delegates tossed all kinds of balls —fair and foul—on those occasions. And Royal Schaaf always fielded them with precision, good humor, and deadly accuracy.

You have heard that today's medicine is cold, efficient, and dehumanized, with the doctor serving as a competent technician, but shrinking from the role of friend and confidant. That could never have been said of Royal Schaaf. His patients adored him. They would wait, sometimes all afternoon, in the big reception room on Mt. Prospect Avenue; wait patiently, for the room was filled; wait expectantly, but never in vain. The shake of his hand, the timbre of his voice, and the twinkle in his eye made them feel better and justified the wait.

He had time for a large practice, time for helping his hospitals, time for Medical-Surgical Plan, time for our Medical Society, time for the Cancer Foundation, and time also to nourish the soul and spirit through artistic, religious, and cultural activities. He was a flutist of no mean skill, and a participant in the famous chamber music medical trio—which included Ben Saslow and Eugene Parsonnet.

The largest newspaper in our State's largest city, not normally given to writing editorials about doctors, did write one about Royal Schaaf. Here is what the Newark *News* said in its April 15th issue:

> In the death of Dr. Royal A. Schaaf, medicine has lost a distinguished member and New Jersey one of its most public-spirited citizens.
>
> He was an eminent surgeon, a pioneer in the fight against cancer, a leader in the establishment and growth of voluntary health insurance, a guiding spirit in the organization of the United Hospitals of Newark.
>
> In these and other useful endeavors, he gave unselfishly of his time and skill to the service of humanity. Dr. Schaaf was a dedicated man who personified the highest ideals of his profession.

Dr. Schaaf was a Trustee of New York University, and he was stricken with his fatal heart attack while attending a luncheon meeting there. Thus he died, as most of us would want to, with his boots on and on active duty.

So now they say that he is dead and that the friendly and effective voice is forever stilled. But this can't be. Somewhere in Heaven there must be room for such happy spirits, such useful servants of mankind. We shall not ask "Rest in Peace," for he never wanted rest. Many of us plead to be excused from "involvement" in the affairs of others. "We have," we say, "worries of our own. Let us mind our own business only." But Royal Schaaf was not afraid to be involved in the worries of others. He committed himself to the advancement of his profession, of your patients and mine, and to the betterment of his fellow-men. Perhaps this is epitaph enough.

The Future of Prosthetics

Science fiction writers used to visualize a depot of human spare parts. Once considered as absurd a dream as going to the moon, this is fast becoming a reality. Some spare parts are essentially cosmetic (a glass eye, for example) and are valuable principally for their emotional effect on the patient. Some are serviceable and respond to the wearer's wishes—like a prosthetic leg. Some seem to function autonomously—like the implanted cardiac pacemaker. Some need to be operated by others on behalf of the subject—the artificial kidney, for instance.

Almost every body function is being studied somewhere by some physician, surgeon, or electronics engineer with the hope of developing an artificial adjuvant to or replacement of the function. Electro-mechanical hearing aides are being worked on to supplement devices for mobilization of the stapes. Soft tissue replacements are being developed so that they can be removed at will and new inserts prepared. Wearers of artificial legs like to show how well they can climb ladders. Many workers are trying to find out how to replace worn out leaflets in the heart valves. Electronic brains, at this writing, are still outside the body; but at any moment now some engineer will find a way to connect with the brain inside the skull. We can partly replace, or supplement, the functions of the kidney, teeth, heart, hair, legs, arms, anus, ears, hands, and larynx. Only the eye today seems completely irreplaceable—but it should not be beyond end-of-the-century (twentieth century, we mean) science to find a way to record visual impressions on the cortex, by-passing the retina.

We worry, of course, about the possibility that implanted plastic may stimulate tumor formation, though the work of Brown[1] and Stimson[2] suggests that these fears are groundless. If we can develop prostheses that can be sterilized or kept sterile, resist mechanical stresses and strains, remain chemically inert and function smoothly, we may finally reach the age of the replaceable man. (But not, let us hope, the dispensable man.) This raises the philosophical question of where man ends and mechanism begins. If a man eats bran for his bowels and waffles for himself, what part of his body is the "self"? If man becomes 50 per cent machine, who—or what—pushes the buttons that start or stop the machine? And if any one deplores the increasing conversion of the human body into a machine, the beneficiary of such conversion can quote DeBakey's[3] comment: This offers the alternative of being incorporated in a machine—or being dead.

---

[1]Brown, J. B. *et. al.* Plastic and Reconstructive Surgery. 26:264 (September 1960)

[2]Stimson, N. E.: *Nature.* 188:678 (November 19, 1960)

[3]DeBakey, M. E.: Quoted in *Hospital Focus* (Orange, N. J., Bilhuber-Knoll) October 15, 1961

ORIGINAL ARTICLES

Patients sometimes lose benefits because of skimpy reports from their personal physicians. This is the first of four articles dealing with the technic of writing a vivid medical disability report.

How To Write A Disability Report†

I. Respiratory Impairment

Earl F. Hoerner, M.D./Newark

To a large extent, it rests with you whether your patient will get the medical disability payments to which he might be legally entitled. It is in your hands, because the medical phase of his eligibility turns pretty much on the way in which you submit the required medical report. Each year, New Jersey practitioners prepare 25,000 such reports. About half of the initial reports just don't spell out the clinical findings clearly enough to permit a determination as to whether the patient is "disabled" within the meaning of the law.

To help you in visualizing what the Disability Determinations Service needs, we are going to present in this JOURNAL some typical examples, problems, and ways of handling them. In this issue we are taking a respiratory impairment as an example. Before the series is over, we will have covered psychiatric, orthopedic, and cardiovascular disabilities.

First, some preliminary explanations. These disability determinations are not made by a cackle of bureaucrats sitting in Washington. They are made by an evaluation team in a *local* agency. The team here in New Jersey consists of a practicing physician working part-time in the Disability Unit of the New Jersey Rehabilitation Commission plus a trained counsellor skilled in vocational evaluation.

The reviewing physician never sees the patient. He works entirely from the report that you submit, plus other written evidence to decide two things: whether the patient has an impairment that qualifies him for disability benefits, and whether rehabilitation services are feasible in his case. Feasibility of rehabilitation is always considered, even if the patient does not qualify for disability payments.

To reach a conclusion as to the severity, duration, and remediability of the patient's impairment, the reviewing physician needs the clinical history, physical and basic laboratory findings, and functional capacity observations. Frequently this evidence is available in the treating physician's records and, on follow-up, is readily obtained from him. This "follow-up," however, takes up your time; and, of course, delays the decision on your patient's case.

The treating physician (and this means you) who understands what is needed can supply the necessary information on his initial report, save his own time, and speed the decision on his patient's claim.

Respiratory Impairment

This patient is John A. Warren of Ladeksbiel, New Jersey * who applied for disability bene-

†This comes from the New Jersey Rehabilitation Commission, Disability Determinations Service, at 309 Washington Street, Newark. Inquiries may be directed to Dr. Hoerner at that address.

* A fictitious name. The records, naturally are confidential.

fits in May 1964. He told the Social Security Office that he had to stop working in January 1964 because of weakness and increasing shortness of breath. He explained that after walking one block on level ground (at a normal pace) he becomes out of breath. Although he has noticed increasing difficulty for several years, it was not until the spring of 1962 that the condition really began to bother him. He had to take off from work frequently, especially in the winter. He took off the week of January 6, 1964, felt a little better, and went back to work. After a few days, however, he felt very weak, stopped working, and hasn't felt well enough to return.

Mr. Warren has been under the care of Dr. Hugh since the summer of 1959. He sees Dr. Hugh about once a month. He could not identify the medicine that his doctor prescribed. He said the treatments did not help him. Mr. Warren had completed seven grades of schooling, started working as a helper on a delivery truck, and, after a few years, became a truck driver, which has been his occupation ever since. In addition to driving, on his last job he had to help load the truck with cases and cartons. Lately, however, he has done very little of that, leaving the loading and unloading to his helper. He worked a 5-day, 40-hour week, occasionally working on Saturday also. His regular salary is $110 a week.

Mr. Warren lives with his wife in a small two-story house. He is now living on savings plus a few dollars a week his married children contribute. He stated (and this was reasonable) that he had not applied for unemployment compensation because his condition would not permit him to accept a job that might be offered to him. Mrs. Warren is not gainfully employed, but works hard doing the household chores. Mr. Warren still cares for his personal needs, but he can't help with any household work or gardening.

Mr. Warren drove his automobile to the Social Security office. He has not driven on any extended trip, however, and tries to avoid heavy traffic. Mr. Warren is a thin person. When he came to the office, he moved around and took his seat very slowly, as if he were trying to avoid unnecessary exertion. He breathed "hard" during the interview and at one point, after bending over to pick up the pen he had dropped, said he felt dizzy.

For diversion Mr. Warren reads, watches television, and visits his children. At the conclusion of the interview, he remarked that he had worked since he was 16 and would like to keep on working, but he feels there is no use even thinking of it now because of his condition.

The Disability Determinations Service sent Dr. Hugh an initial medical report form—we call it a D-826, but you don't have to worry about the number. Here are the questions asked (smaller type) and Dr. Hugh's answers (regular type). Notice how Dr. Hugh's answers seemed to be all right for a casual case summary—and how they failed to help the team evaluate the case.

Height and Weight:
67½ inches and 123 pounds.

Subjective symptoms
Labored respiration and chest pains.

Objective findings:
X-ray evidence of pulmonary emphysema.

Is applicant ambulatory, bed-confined, wheel-chair-bound, house-confined, or hospitalized?
No answer was given.

Diagnosis:
Pulmonary emphysema.

Date of first and last visit:
No answer given.

Frequency of visits:
No answer given.

Therapy and response:
Condition static.

When did you last examine the applicant?
No answer given.

What optimum improvement can be expected, if any?
No answer given.

When do you think he will achieve optimum improvement? 6 months? a year? indefinite?
No answer given.

Describe specific restrictions, if any, on patient's activity:
Restrict physical activity and restrict exposure to cold.

For respiratory disability, please amplify below with latest findings and dates—frequency, duration, and severity of acute attacks; deformity, if any, of chest wall; findings of emphysema; vital capacity; indicate the kind of activity which results in dyspnea.
No answers were written in this block.

This report did indicate that the patient had an impairment, but did not permit a reviewing physician to determine (precisely enough for disability evaluation purposes) the severity of the impairment, the patient's work capacity limitations, or his remaining capacity to perform work-related functions. Without such information, the evaluation team cannot conscientiously determine whether to allow or deny the patient's claim. To get enough information to make a sound decision, they wrote to the treating physician, who provided the following historical, physical, and laboratory data from his files:

Dear Doctor Hoerner:

In reply to your request for additional information on Mr. John A. Warren, I can provide the following:

Mr. Warren first began to notice shortness of breath about six years ago and recently began to be *short of breath on walking one block on level ground at a normal pace, or climbing one flight of stairs.* He even becomes short of breath disrobing for an examination. I have noticed *shortness of breath and cyanosis of the lips after he has walked the single short block to my office.* He has been a truck driver for the last four years. In the last few years he has been very susceptible to colds and was absent frequently from work in the winter months. With changing weather or with upper respiratory infections, he notices wheezing, tightness of the chest, and marked breathlessness even at rest. He has been unable to work since last January. His usual weight was about 166, but in the last two years *he has lost 40 pounds.* He now has a poor appetite. There is a slight productive cough chiefly in the mornings. He feels very weak and becomes dizzy on stooping over. Even lifting one or two light packages causes shortness of breath and pain across the chest. *Treatment, has included antibiotics and bronchodilators, with little response.*

Mr. Warren is a thin man who appears slightly undernourished. Mucous membranes of the nose are clear and the passages are normal. *Neck vein distension is seen when the patient is lying down.* The chest is long and thin and held in slight inspiratory position. *The respiratory effort is primarily thoracic and there is retraction of the supraclavicular fossa with each breath.* The chest is symmetrical without inequality. *There is obvious prolongation of the expiratory phase.* Chest measurements are 33.5" on full expiration and 35" on full inspiration. *The percussion note is hyperresonant throughout. The breath sounds are very distant.* No rales or rhonchi are heard.

The heart is accelerated to a rate of 108. Blood pressure is 150/70. *The left border of cardiac dullness is 10 centimeters from the midsternal line in the sixth intercostal space.* Sounds are of good quality but slightly distant. There is a regular rhythm without abnormality. No murmurs. P-2 is greater than A-2.

The abdomen is scaphoid and the liver tender four fingerbreadths below the right costal margin at the mid-clavicular line. Strength and motion of the extremities are normal.

The fingers show evidence of clubbing, and the nail beds and lips are cyanotic. The ankles show evidence of 1 plus edema. The hands and feet are cool. The pulses are present in all extremities. The femoral, popliteal, dorsalis, and posterior tibial pulses are all palpable.

Chest x-ray reveals a normal bony skeleton, the trachea in the midline. *The pulmonary arteries appear enlarged. The hilar markings are increased. The lung parenchyma reveal increased radiolucency. The intercostal spaces are increased.* The domes of the diaphragm are flattened and appear at the 10th rib during full expiration. *The heart measures 16 centimeters in a total chest measurement of 26 centimeters. Fluoroscopy reveals two centimeter motion of the diaphragms bilaterally.*

(Blood count and urine analyses reports were attached.)

This is a good letter. It didn't take Dr. Hugh too long to write, and it gave the Disability Determinations Service a vivid picture of the problem. Note particularly the italicized clauses in the letter. These showed objective or concrete findings: *distention of the neck veins is seen when the patient is lying down;* or *retraction of the supraclavicular fossa with each breath.* Note how much clearer this is than the conventional "findings are typical of emphysema." Observe the vividness of *cyanosis of the lips after he has walked the single short block to my office.* Dr. Hugh is not only a cooperative doctor who is helping his patient get a benefit he is entitled to; he is also a keen clinical observer. If he had transcribed this to the initial report this would have saved time for all of us—the patient, the treating physician, and the evaluation team. And this, we hope, will result from the articles in this series.

Conclusions

In all cases, we need a meticulously dated history; physical findings which give facts in concrete, objective, and specific form; laboratory data; your observations on functional limitations. This we need in all cases.

When the impairment is respiratory, we need, in addition (a) a word-picture of the patient's physical appearance; (b) results of ventilatory tests, if they are available; (c) x-ray findings; and (d) a good picture of the kind of activity that results in shortness of breath.

309 Washington Street

Excellent results were achieved in young people with intractable bronchial asthma by excision of the carotid body.

Cervical Glomectomy for Bronchial Asthma*

George L. Kline, M.D.
Mario P. Ponce, M.D.
Spyros Philippakis, M.D.
Peter Amirata, Jr., M.D.
Newark

Excision of the carotid body is not the first surgical procedure for the treatment of bronchial asthma. In 1923 Kummell[1] advocated resection of the superior cervical sympathetic ganglion. This was often followed by Horner's syndrome and parotid pain. Then in 1924, Kappis[2] sectioned the vagus nerve. His three year follow-up revealed very few patients improved. In 1928 Gobell[3] combined both procedures by performing bilateral superior cervical ganglionectomy and severing the right vagus nerve. Results were no better than for either procedure. His mortality rate was significant. In 1961 Nakayama[4] reported excision of the carotid body and followed over 3900 cases. His results revealed 81 per cent cured or improved six months after surgery; 73 per cent good results at two years; and 58 per cent still had good results after five years. In 1957 Overholt[5] was stimulated by Shiraha who worked with Nakayama and was familiar with his procedure. Benefits were encouraging and complications few. In 1962 we visited Overholt at Boston and found that his results were the same as Nakayama's. At this time we were encouraged to try our own series, and to compare results.

Anatomy

Haller[6] described the carotid body in 1743. Schaeffer[7] describes it as a "thin, ovoid or triangular nodule from 5 to 7 millimeter in length and 2.5 to 4 millimeters in width, located at the bifurcation of the common carotid artery, and of a grayish or brownish-red color." To us, it looks like a rice grain size structure (sometimes even smaller) at the bifurcation of the common carotid artery, yellow-pink in color, and embedded within the carotid plexus and adventitia of the vessel wall. It is supplied by the carotid body artery and occasionally is of significant size to require ligation. In one of our cases, the body was found about 2 centimeters from the bifurcation on the lateral surface of the external carotid artery. The nerve supply, reported by Nakayama[4], comes from a plexus contributed by the parasympathetic and sympathetic systems. This plexus contains glossopharyngeal and probably vagus fibers, and periarterial fibers from the superior cervical ganglion.

Physiology

The carotid bodies are chemoreceptors[8] acting as regulators of respiration and circulation in their intermediate position in the autonomic nervous system. They respond to variations in carbon dioxide and oxygen tensions and pH of blood by effecting changes in respiratory rate, blood pressure, and red cell count. Since the carotid body is intimately connected between the sympathetic and parasympathetic system, it may influence the tone of the bronchial musculature. Excision of the carotid body partly interrupts the pathways between the pulmonary plexus and the midbrain. In patients with low vital capacity there is often an increase. In our series, vital capacity and timed vital capacity were studied pre-operatively and post-operatively in 5 patients. Though the post-operative pulmonary studies were done the second post-operative day, we found an increase in vital capacity 200 cubic centimeters only. Significant increase was found in timed vital capacity —average 200 per cent for the first and second seconds.

The effect on the cardiovascular system in a 6-month follow-up of a group of patients by Nakayama[9] shows the normo-tensive to be unaffected by glomectomy. The hypertensive has a significant reduction in blood pressure and an increase was found in hypotensive patients.

*Read February 25, 1964 at the sectional meeting of the Tennessee and New Jersey Chapters of the American College of Surgeons, Mexico City, Mexico.

Technic

The technic we used for excision of the carotid body is that described to us by Overholt[5]. It is done under local one per cent lidocaine† anesthesia. A horizontal incision is made in a natural crease one-third the distance between the angle of the mandible and the clavicle on the right side of the neck. The sternocleidomastoid muscle is retracted externally. The carotid bifurcation is exposed. When necessary for good exposure, the superior thyroid artery is ligated and divided. With an elastic band around the external carotid artery used as a traction, the medial surface of the bifurcation is exposed. With blunt and sharp dissection the bifurcation is cleared of its adventitia and the tissue surrounding the carotid body. Occasionally it is difficult to locate the carotid body. We have tried to remove the tissue en bloc. No sutures are necessary in the muscular or subcutaneous layers unless unnecessarily a large exposure was made. Drainage of the wound is unnecessary.

Clinical Study

For this study we selected 24 patients admitted to the City Hospital and St. Barnabas Medical Center (both in Newark, N. J.) with intractable chronic bronchial asthma. Intractability was gauged by the duration of the disease, frequency of attacks, and failure to respond to medical management, which in many cases included the use of corticosteroids.

Our group of 24 cases consisted of 15 female and 9 male patients whose ages varied from 12 to 72 years. Pre-operative evaluation included history, physical examination, blood chemistry, urinalysis, sputum studies, chest x-ray, and electrocardiography when indicated. In 5 cases, pulmonary function studies were performed. In 4 patients, the oldest of our group, the chest x-ray reported emphysematous changes. Two other patients were pregnant (12 and 20 weeks). Follow-up was a minimum of six months. Our study is based on a six month period.

Results

We classified the results in 4 groups:

1. *Excellent*—For patients who have been free of attacks up to the last follow-up visit.
2. *Good*—For patients who have had only one or two mild attacks post-operatively, but do not depend upon medication.
3. *Fair*—For patients who have had one or two attacks, but continue to take medication.
4. *No Improvement.*

In 16 patients out of the 24, the report of material removed was that of carotid body and nerve tissue. In the remaining 8, the pathologist failed to identify the carotid body, finding nerve tissue only.

Patients in whom excellent and good results were obtained were in the age group of 12 to 36 years. Those over the age of 36 showed fair to no improvement.

Results are summarized in the table.

TABLE I

Results

Excellent	11	or	46%
Good	4	or	17%
Fair	5	or	21%
No Improvement	3	or	12%
Lost to Follow-Up	1	or	4%
TOTALS	24		100%

TABLE II

Pathologic Findings

Carotid Body Present	16	or	67%
Nerve Tissue Only	8	or	33%
TOTALS	24		100%

TABLE III

Results in patients in whom the carotid body was removed:

Excellent	10	or	62%
Good	2	or	13%
Fair	2	or	13%
No Improvement	1	or	6%
Lost to Follow-Up	1	or	6%
TOTALS	16		100%

TABLE IV

Results in patients in whom the carotid body was not identified by pathologist:

Excellent	1	or	13%
Good	2	or	25%
Fair	3	or	37%
No Improvement	2	or	25%
TOTALS	8		100%

†We used the Astra brand of lidocaine tradenamed Xylocaine®.

Conclusions

1. Twenty-four cases of cervical glomectomy are presented.

2. Unilateral cervical glomectomy was found of value in intractable chronic bronchial asthma.

3. Removal of the carotid body is essential for good results.

4. The younger the patient, the better the results.

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425 Mt. Prospect Avenue

Surgical Treatment of Nonobstructive Jaundice.

In certain, carefully diagnosed, nonobstructive jaundice cases the surgical treatment is very effective. Not all cases of nonobstructive jaundice are due to infectious hepatitis. According to the authors, the nonobstructive jaundice can be caused by (1) functional inhibition of bile secretion; (2) reflex spasm of Oddi's sphincter; (3) excessive reabsorption of water in the hepatic cells as in drug-induced cholestasis (chlorpromazine, methyltestosterone); (4) hepatitis or hepatosis; (5) chronic hepatitis and hemolysis (discrepancy between reduced bile secretion and increased bilirubin); and (6) the association of an organic (hepatitis) and a functional (spasm of Oddi's sphincter) process. The choice of surgical management or conservative treatment should be based on the findings in each individual patient.

J. Pavel, S. Campeanu,
M. Pirvulescu, and C. Dumitrescu
Muenchen Med Wschr 105:1554 (Aug 2) 1963

Mediastinal Cysts: A Clinicopathologic Study on Twenty Cases.

Twenty cases of primary mediastinal cysts are reviewed. The bronchogenous variety was the most common and the thymic cyst the least common. All the gastric cysts were encountered in children under one year of age. Less than 50% of all the patients in this study were symptomatic, most cases being discovered on routine chest x-ray examination. Clinical and/or radiological findings were not specific either for the group of mediastinal cysts as a whole or for a specific variety of cysts. However, thymic and pericardial cysts were located in the anterior mediastinum while gastric, bronchogenous, and undesignated cysts tended to be found in the posterior compartment. Surgical extirpation proved to be adequate therapy for all the cysts. In none of the cases was there any evidence of malignant degeneration.

M. R. Pachter
Dis Chest 44:416 (Oct) 1963

Atropine poisoning is rare and easily overlooked. But it is the doctor's job not to overlook the obscure.

Atropine Poisoning In A Child

John K. Butler, M.D./East Orange

Accidental poisoning is well known in toddlers. Moreover, in cases that present bizzare signs and symptoms it is wise to keep in mind the possibility of an underlying poison. I am here reporting a case of atropine poisoning. A red herring (literally and figuratively) helped unravel the diagnostic puzzle.

Ask any pediatrician what he knows about atropine poisoning, and he's most likely to mutter something about the Jimson weed. In addition he will add "dry as a bone, blind as a bat, red as a beet, and mad as a hatter." But the child with atropine poisoning doesn't show up with these four labels pinned on him. Sometimes it takes a little detective work to make the diagnosis.

Children are especially susceptible and many cases have resulted from the conjunctival instillation of these alkaloids because absorption occurs from the nasal muscosa after the drug has entered the nasolacrimal duct or from the intestinal tract if it is swallowed. In young children the fatal dose is probably in the neighborhood of 10 milligrams. The ordinary eye-drops contain that much in every cubic centimeter. Therefore, ingestion of just five drops containing 2.5 milligrams would give a two-year-old toxic symptoms. The toxic symptoms in an adult[1] ingesting 5 milligrams are rapid heart rate, palpitation, xerostomia, pupils dilated, some blurring of near vision, restlessness combined with fatigue, and hot dry skin.

Lisieux[2] describes a fatal case in a three year old boy who ingested a 10 cubic centimeter vial of atropine eye drops. Lisieux says that there is no specific antidote to atropine. Pilocarpine is not only useless but adds to the state of intoxication.

At eleven o'clock on a Saturday morning a two-year old girl was brought to the emergency room. She had apparently fallen out of bed. Her wildly, excited condition was hardly explainable by what appeared to be a minor accident. The intern reported over the telephone that the child was excited, had wildly dilated pupils, and that her skin was brick red all over the body. He found it difficult to explain the picture, and in desperation summed it up that "she's acting very funny."

A skull x-ray (which was subsequently reported as negative) was ordered, and an hour later the child was examined by the writer.

The parents told me that the child had been perfectly all right that morning: now—they lamented "she doesn't even recognize us." That morning had been a busy one in the household. A family party was in preparation, and the patient was told to go upstairs and rest in her bed. Three-quarters of an hour later she was heard to fall out of bed.

During examination the child had to be restrained. Her pulse was 180 per minute, temperature 100.8. Her skin was bright red, hot and dry. Both pupils were widely dilated and unresponsive to light. The reflexes were hyperactive. No pathologic reflexes were elicited. The remainder of the examination was within normal limits.

Spinal fluid was crystal clear and under no increased pressure. The laboratory reported no cells present. Sugar was 20 milligrams per cent, and protein 40 milligrams per cent.

The child was then admitted to the pediatric ward with orders for phenobarbital, one-eighth grain every four hours; gentle restraints; and alcohol sponges as indicated.

Meanwhile, the parents were questioned more closely about the events of the morning, particularly the possibility of accidental poisoning. They denied that any medications were within reach of the patient.

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but the presence of four older children who might have "helped her out" couldn't be eliminated. The symptoms were suggestive of atropine poisoning. The parents were asked if there were any belladonna preparations in the home. It then appeared that the child's grandmother had just moved into the home following an operation for removal of a cataract. She had atropine eye drops. These drops were left on a low night table. Later, the eye drops were found with the cap loosened, indicating the source of the poison. One of her older siblings had "helped" our patient.

The child made an uneventful recovery and was discharged on the third hospital day.

Summary

1. Atropine in minute quantities is a severe, and sometimes fatal, poison for children.

2. A combination of symptoms unexplainable in a child should elicit the suspicion of poisoning.

144 South Harrison Street

Psychiatric Course for GP's

Seton Hall College of Medicine offers a course in psychiatry for non-psychiatric physicians at Medical Center, Jersey City, beginning Wednesday, May 20. It will be given Wednesdays from 10:00 a.m. to noon, for a six-week period, and is approved by AAGP for 12 credits.

The course will include practical material concerning office management and diagnosis of a wide range of frequently encountered problems. Anxiety, depressive states, sexual disorders, and psychosomatic difficulties are to be discussed. It is open to any physician and is offered free of charge.

Also offered is a somewhat more technical program of Wednesday noon luncheon sessions moderated by prominent psychiatrists. The next topics are: *The Murderer* (May 20); *Schicophrenic Concepts of God and the Devil* (May 27); *Emergency Psychiatric Clinics* (June 3); *Psychiatric Care in Africa* (June 10); and *The Psychiatrist as a Witness* (June 17). All physicians are welcome to attend the noon sessions, too. Those who come for the 10:00 a.m. program may find it interesting to remain at the Medical Center another hour and a half and sit in on these meetings, also.

Academy of Medicine Library Acquisitions

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Pain seems like a simple symptom, easy to localize. But accurate localization takes meticulous study of the case.

Pain IV*: Its Place of Origin

Fred A. Mettler, M.D./New York

It would seem that it should be easy to decide where a pain is coming from. In practice, however, many treatments are inadequate because they are not based upon an accurate determination of the origin of pain. The relative importance of organic causes of pain, and also the different qualities of pain, have already been considered[1] but, assuming that a real cause of organic pain does exist (and that the reaction to it is not psychopathologic) what are the principal difficulties in deciding where it comes from?

Obviously one cannot make much progress in the treatment of pain without an accurate knowledge of anatomy, including the location and connections of sensory nerves and other significant structural aspects of such parts as joints, tendons, the insertions of muscles and of distensible viscera and vessels. The first questions in dolorology to be answered are whether an examination of the region discloses (1) any abnormality in its structure and function (other than pain) and, if such abnormality exists, whether there is (2) any inconsistency in what is to be expected on the basis of such a local disorder and (3) if the local phenomenon to which attention has been directed is really the primary organic difficulty.

The usual reason for failing to arrive at an adequate decision as to whether there is any abnormality in the structure and function of a part is an incomplete or unenlightened examination. Before any thought of taking an x-ray arises, the all too frequently neglected (and time-consuming) physical examination of the stripped moving patient must be intelligently concluded. It is necessary to form separate mental images of all the structures in the vicinity and to determine, by palpation and the use of active and passive movement, which structures are and are not related in any way to the various qualities of the pain. If one cannot adequately examine the patient either because of age, language barrier, psychosis, emotional antagonism, or circumstance (such as in the case of the victim of an accident in a difficult traffic situation) such facts should be specifically noted in a record which should *invariably* be made of every examination no matter how casual or apparently trivial. The patient with vague, generalized, poorly localizable pain, including muscle pain and headache, and who is having obvious environmental adaptive difficulties, deserves special attention. Impaired psychic or emotional capacity may be part of generalized processes (especially neurosyphilis) which are also characterized by pain and which should be suspected if a patient looks chronically ill. Collagen disease, leukemia, and carcinomatoses should be kept in mind.

Having come to a decision as to what structures seem to be involved in the painful process, one should ask oneself whether any functions of these parts are non-painful and, if so, whether this is consistent with the hypotheses so far formed and if not why not. Consistently reported pain and tenderness may exist in a particular area where the function of the part is much better than one would expect. Such a circumstance should lead the examiner to suspect referred pain. Never terminate an examination of any painful state, even though an adequate cause for the pain has been found, without searching for other possible coexisting causes.

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* From the Departments of Anatomy and Neurology at Columbia University, this paper is based on an address to a staff conference at the Department of Anesthesiology there on May 21, 1963.

[1]Mettler, Fred A. JOURNAL of The Medical Society of New Jersey, 61:10, 62, 113 (1964)

Referred pains are of two general types: (A) pain felt in regions where no structural changes exist, and (B) pain experienced in a location where a secondary painful cause has arisen because of primary pain somewhere else.

The commonest variety of the *first* general type is pain felt in the periphery of the body as the consequence of stimulation in the course of a nerve. Typical examples are such as may be due to the pressing of nerves against bony prominences (cervical rib, costoclavicular syndrome, or ulnar nerve compression between the trochlea and medial epicondyle of the humerus) or caused by specific pathology in the nerve itself as occurs in those damaged or partially divided nerves where causalgias develop. The mechanism of the production of pain in causalgia is irritation of the nerve in course. It is due to ephaptic (cross-over conduction) or false synaptic transmission. The normally transmitted efferent autonomic impulses conducted in sympathetic nerves, which run with the peripheral blood vessels, spill over into the sensory fibers of the injured nerve. It is a case of direct stimulation of somatic sensory nerves by sympathetic efferent fibers. This is why causalgic pain is so closely correlated with vegetative discharges and why it is amenable to sympathectomy. A *second* variety of the first general type is "phantom limb pain" in which the pain is projected beyond the parts of the body which remain. A *third* variety of referred pain, appearing in an area where no structural change exists, is pain experienced in a dermatome at some distance from the locus of a diseased viscus which developed embryologically in that dermatome and then migrated elsewhere and carried its nerve supply with it. Such pains are those felt in the arm as a result of aortic tension, or in the supraclavicular region when the diaphragm is inflamed. All pains of the general type A disappear when the nerves proceding from the primary diseased site are blocked.

In the second general type (B) of referred pain (and the only one often implied by the use of this term) blocking of the afferent path from the primary diseased site to the cord does *not* immediately abolish the pain. The usual explanation for this is an ephaptic phenomenon, (spread of irritation) occurring among the cells of the dorsal horn. Explanations of this type help to understand why changes are demonstrable *in* the actual site of reference and why anesthetization of that region abolishes the pain. The primary phenomena are more easily explained by the assumption that the referred pain is actually due to vasoconstriction occurring in the vessels of the site of reference. Vasomotor discharge may be evoked throughout an entire dermatome which contains a primary visceral lesion. In some instances, the boundaries of the cutaneous site of the referred pain can be demonstrated by differences between such vasomotor effects in the affected dermatome and uninvolved neighboring areas.

It is usually not difficult to distinguish between pain of root origin, or from a proximal mixed nerve, and that caused by involvement of a nerve in course; but the only way to achieve facility in recognizing the characteristics of involvements of plexuses or nerves in course is through familiarity with anatomy. It is unwise to adopt a dogmatic attitude about what particular spinal root or peripheral nerve one may be dealing with not only because of variation in normal neuroanatomy but also because different types of lesions of the same structure yield information of a somewhat different nature. Specifically, the effect of loss of function of a particular nerve root may be difficult to detect because of overlap, whereas pain due to irritation of the same root may be experienced in a surprisingly wide area. Further, the results of examinations conducted at different times are likely to vary because of progressive changes in the sensation of the region.

The characteristics of various types of pain, as well as their relationship to the time of day, to exercise, and to barometric conditions, are well known and do not require comment here but it is worth emphasizing that many neurologic disorders give rise to pain as a result of imbalance in muscle status rather than because of neural involvement of pain fibers *per se*. Pain is also a common occurrence in persons whose muscles exhibit increased tone, either because of voluntary tension due to apprehension or because of involuntary rigidity, even though this is of a symmetrical nature. Complaints of pains which are reported as "starting

here and running to here and here" should, if they follow no obvious neurologic substrate, lead one to explore the possibility of musculoskeletal imbalance or episodes of increased muscular tension.

Because of its close relation to emotional changes and straining, pain of vascular origin is ordinarily easily identifiable, if one remembers to consider it.

This discussion of the place of origin of pain cannot be concluded without specifically reemphasizing the necessity for the physician to be on his guard against attributing any particular pain (1) to the cause assigned to it by the patient, or, (2) to an apparently adequate structural cause, *without excluding other possible causes*. Few physicians fall into the trap of giving full faith and credit to a patient's statement about what may be the cause of his pain, but the present writer's experience on The Medical Society of New Jersey's Committee of Medical Defense and Insurance leads him to conclude that it is not superfluous to insist that the examining physician should *always* search beyond the first adequate cause he encounters for any particular pain. It is worth remembering that it is the cause that is overlooked (not the one which is found) which turns up in a professional liability suit.

630 West 168th Street

Radiological Diagnosis of Gastric Atrophy.

Gastric biopsies and roentgenographic studies were performed on 82 patients investigated for iron-deficiency or pernicious anemia, steatorrhea, thyrotoxicosis, or diabetes mellitus. Each patient took 4 to 5 oz of barium sulfate suspension and was postured so as to allow barium flow over the stomach surface. Discrepancies between radiological evidence and biopsy findings indicated the need for a comparative study of normal and atrophic gastric folds for differential diagnosis in pernicious anemia. Normal folds mean absence of pernicious anemia and show that the examination should be extended to the small intestine. Lack of agreement between radiological evidence, results of augmented histamine test, and gastric biopsy findings, indicates that either the patient is not suffering from pernicious anemia, or there has been an error in one of the techniques. A routine barium meal examination can give reliable evidence of gastric atrophy provided adequate details of the mucosal surface are obtained.

O. A. A. Bock, F. H. Kemp and
W. C. D. Richards
Brit J Radiol 36:578 (Aug.) 1963

Carcinoma of the Bile Ducts.

The results of surgery in carcinoma of the bile ducts are discouraging. Despite the fact that the tumors are generally slow growing, and metastases may not have developed, death is due to obstruction of the bile flow. Postmortem examinations have revealed that the lesions are technically resectable in some patients. This observation should encourage the surgeon in his attempts at curative resection of bile duct tumors. When curative resection is impossible, diversion of bile into the gastrointestinal tract is paramount for the relief of symptoms. Surgery without diversion of bile to the gastrointestinal tract will hasten the patient's death. Twenty-six cases of malignant tumors of the extra- and intrahepatic ducts, exclusive of the ampulla of Vater, encountered in the pathological material at Cook County Hospital, Chicago, since 1941 are reported. The possibility of carcinoma of the bile ducts, as the primary pathology, merits consideration in every patient with obstructive jaundice, particularly in the aged.

E. L. Strohl et al
Arch Surg 87:567 (Oct) 1963

Epispadias in the female is rare enough to justify reporting. In this compact essay, Dr. Fadil points up the effectiveness of nonsurgical therapy.

Female Epispadias*

Richard Fadil, M.D./Passaic

Epispadias in the male is uncommon, but most urologists have seen it. In the female, however, it is very rare. The incidence (reported by Dees[1]) was found to be one in about a half million hospital admissions. Others[2] have reported higher figures, but Dee's ratio would seem more consistent with the sparse reports on the subject in the literature. The case of the patient here reported is the only known case of female epispadias ever seen at this 800-bed Newark City Hospital.

In the male, the lesion is easily identified with the urethral meatus opening on the dorsum of the penis, usually the penopubic area, with a dorsal cleft between the corpora cavernosa. The corpus spongiosum is hypoplastic or absent, and the penis is small and somewhat flattened. The foreskin is absent on the dorsum and redundant ventrally.

In the female this deficiency of the roof of the urethra is not so obvious. The urethra is located anterior to its normal position, and unusually short. The meatus is large, gaping, and pit-like (Fig. 2). The clitoris is bifid, and the labia minora and majora fail to converge anteriorly. The mons veneris frequently bears a shallow, midline, relatively hairless depression. Advanced stages of epispadias with defects extending through the bladder neck and with pubic bone separation may occur. Incontinence of varying degree is usually present. The upper urinary track is normal in one-third of these patients while the female genital tract is generally normal

Genesis

The commonly accepted explanation of the embryologic defect causing epispadias is that offered by Patten and Barry[3]. The sequence of aberrations begins in the early weeks of embryonic development when the genital tubercle primorida are still in their paired condition. These are initially located farther caudally than normally occurs, so that when the urorectal membrane grows down to the region of the genital tubercle and cloacal membrane it presents itself anterior to the tubercle rather than posterior to it. Thus the corpora cavernosa would form caudal to the embryonic urinary tract, leaving the urethra to lie on their dorsal surface rather than their ventral surface. Failure of midline convergence of the primordia would account for the split clitoris seen and the partially separated corpora cavernosa in the male.

The cloacal membrane is normally reinforced by an ingrowth of mesoderm toward the midline. When this fails to occur, the normal dehiscence in this structure to form the urinary tract outlet may be exaggerated and lengthened in a cephalic direction. This results in the splitting of the roof of the primitive urinary tract. The extent of this embryonic cleft will determine whether the resultant condition is a simple epispadias with continence or, in the most extreme degree, if the entire urethra, bladder, and anterior pelvic bones are laid open. This latter state, bladder extrophy, is then seen to be the extension of the embryonic developments that cause epispadias. Gradations between these extremes, anatomically and functionally, are observed clinically[4].

*This paper was entered in the prize essay contest sponsored by the American Urologic Association. The work was done at the Newark (N. J.) City Hospital. Dr. Fadil read the paper at the New York Academy of Medicine, April 17, 1963.

Surgical Treatment

Surgical treatment for epispadias, if indicated, is usually directed toward bringing the abnormal urinary tract, anatomically and thereby functionally, closer to normal. Most procedures involve urethral lengthening technics which would increase urethral resistance and promote continence after principles described by Lapides[5].

The earliest of these procedures in the female involved the dissection of mucosal flaps about the abnormal urethral orifice and their approximation and reinforcement in the midline, thus lengthening and narrowing the urethra from its distal end. In the male, urethral lengthening is accomplished by plastic methods[6], which result in a newly fashioned urethral tube extending from the abnormally placed urethral meatus along the length of the penis.

Procedures at the bladder neck to increase urethral resistance have utilized the pyramidalis muscle (Goebell, 1910), the rectus muscle (Thompson, 1923), the anterior colporrhaphy (Stoeckel, 1920), the placing of transverse reefing sutures at the bladder neck to lengthen and narrow the urethral tube (Stettinev, 1914), and, more recently[7], the Marshall-Marchetti operation[8]. Young[6] in 1922 reported two cases in males in which he excised portions of the anterior bladder neck and the roof of the prostatic and membranous urethra and then reapproximated both urethra and voluntary sphincter, with a satisfactory result. Campbell[2] used this operation with an "excellent" result in five of six females.

Case Report

This was the fifth hospital admission of a 19-year old, unmarried woman with a history of enuresis as a child, frequency, urgency, dysuria, and nocturia (3 to 4 times a night) for as long as she could remember. Frequently she had "teaspoonful" voidings every one-half to one hour, and at such times she "usually could make it to somebody's bathroom." Because her urinary stream was forceful and directed anteriorly, she acquired the pattern of voiding from a standing position, crouched far forward in order to direct the stream into the receptacle below rather than over it. She lost urine occasionally on coughing or straining, and had mild left flank pain for two months prior to admission. She never had hematuria.

She had had a spontaneous abortion with appendectomy four years prior to admission, followed by two admissions for salpingo-oophoritis and one for mon-articular arthritis. She denied having had gonorrhea and syphilis by name, but reported intermittent foul-smelling vaginal discharge, associated with lower abdominal pain for seven years previously. There are no menstrual irregularities. Six other siblings have no enuresis or other urinary symptoms.

She was an alert, happy, well-developed girl. Head, neck, heart, lungs, and breasts were normal. There was mild tenderness to deep palpation in the right lower quadrant with no rebound tenderness. Neurologic examination was negative. Rectal examination was normal, with good sphincter tone. Pelvic examination revealed a normal fundus with no adnexal masses or tenderness.

Escutcheon was that of a normal female with sparse hair in the region of a shallow midline furrow. (See Figures 1 and 2).

The labia majora and minora failed to converge anteriorly. The urethral meatus was large, patulous, pit-like, and situated between the anterior ends of the labia minora and anterior to its normal location. The clitoris was divided, with each of its two moieties identifiable as soft 6 millimeter lobules on the labia minora.

Cystoscopy and urethroscopy revealed a generalized injection of the bladder mucosa but no exudate, ulceration, or hemorrhagic areas. Both ureteral orifices were normally placed, discharging clear urine. The bladder neck as viewed with the fore-oblique telescope was broad and distinctly more widely open than normal. The urethra was 15 millimeters long by urethroscopic and balloon catheter measurement, with normal mucosa.

Observation of the patient's voiding confirmed that she remained standing, straddling the bowl and bent far forward to direct the stream into the bowl below.

Stress test in the lithotomy position with instillation of 90 cubic centimeters into the bladder and firm cough demonstrated a stong jet of urine directed toward the ceiling.

Two cystometrograms revealed normal pressures. At 100 cubic centimeters and 150 cubic centimeters of filling, a sudden strong urge to void occurred. Bladder capacity was 200 and 250 cubic centimeters.

Pyelogram showed normal kidneys and ureters. Only four lumbar vertebrae were present. The symphysis pubis was normal. Cystogram indicated normal position of the bladder. The voiding cystogram revealed exaggerated funneling and bladder descent.

Hysterosalpingogram showed no evidence of congenital abnormality.

The blood picture was within normal limits.

Urine was acid with a 1.020 specific gravity. No sugar or albumen was found, but she showed 8 to 10 leukocytes per high power field. On culturing the urine, the laboratory reported staphylococcus albus (nonhemolyticus) sensitive to erythromycin and to kanamycin sulfate (Kantrex®).

Course: Patient was placed on sulfisoxazole and nitrofurantoin, each four times a day. After one week of therapy, diurnal frequency was reduced to every two hours without urgency and the nocturia to once a night. After two months she had no nocturia while she was still taking sulfisoxazole alone. After ten months she continued without urinary symptoms and without medication.



Fig. 1. External genitalia demonstrating failure of labia majora and minora to converge anteriorly. Note sparsity of the midline hair.



Fig. 2. The labia separated, with the clamp pointing to the patulous pit-like urethral meatus. Note the bifid clitoris with a moiety on each side of the urethral meatus.

The Marshall stress test now showed no loss of urine with strong cough at 90 cubic centimeters of filling. Follow-up cystometrograms demonstrated an increase in bladder capacity to 300 cubic centimeters.

It is surprising that this 19-year old female with a life-long history of urinary symptoms and four previous hospitalizations had not come to urologic evaluation and diagnosis before this time. This case demonstrates the competence that the female urethra may display even when considerably shorter than normal. It was only 15 millimeters long in this patient. The marked anterior direction of the urinary stream has never before been reported as associated with this disorder, though it is not surprising when one considers that the urethra itself is anteriorly misplaced. Although this finding and all of the patient's symptoms responded dramatically to anti-bacterial therapy, incapacitating incontinence may occur in the future with aging or with pregnancy and vaginal delivery. This situation would require surgical correction.

Summary

The clinical features, embryology, and modalities of treatment of epispadias in the female are reviewed as reported in the literature. A case is presented with a previously undescribed finding and good therapeutic result following simple antibacterial therapy.

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20 Grove Street

Barium rarely gets into the biliary tract. When it does, look for incompetence of the sphincter of Oddi.

Incompetency of the Sphincter of Oddi*

Aaron Schwinger, M.D./Glen Rock

The demonstration of barium within the biliary tract is an uncommon radiographic finding. The rarity of this finding has prompted the following case report. We will not discuss internal biliary fistulas and their varied etiologic factors. This report concerns regurgitation of barium through the sphincter of Oddi.

A 63-year-old woman was admitted to the hospital* with abdominal pain of two years duration increasing in severity and frequency. The gall bladder could not then be radiographically visualized. However, for personal reasons, there had been no further therapy. At the time of admission, pain was severe. Remainder of the history was not remarkable or pertinent. Physical examination was non-revealing, except for tenderness in the right upper quadrant.

At the laporotomy, the liver was smooth and normal in size. The duodenum was drawn up and adherent to the gall bladder. The gall bladder was shrunken, thick-walled, and showed evidence of an old perforation which had been sealed off by the adjacent duodenum. There were multiple calculi within the gall bladder and two large calculi within the common duct. There were no stones within the hepatic ducts. A T tube was placed in the common duct. Figure 1 shows the post-operative cholangiogram. Note the dilatation of the common duct, along with some reflux into the pancreatic duct. There was some delay in drainage into the duodenum, but no evidence of calculi. The final pathologic diagnoses were chronic cholecystitis and cholelithiasis.



The patient's present admission occurred five years later. She had been well in the interim, except for a history of "orange discoloration" of the skin two years previously. She received no medical attention for this "'discoloration", which cleared in two weeks. Present admission was precipitated by abdominal pain, localized to the upper quadrants, with associated vomiting of 48 hours. Chemistries, including amylase and bilirubin, were normal. A study of the upper gastro-intestinal tract revealed barium within the biliary tract. The finding is illustrated in figures 2 and 3. From the illustrated barium filled anatomy, the diagnosis of regurgitation into the common duct was made.



At surgery, it was found that the common duct was thickened. The opening into the duodenum was described as large and admitted the tip of the fifth digit. There were no calculi. There were no lesions in the duodenum or stomach. There was no evidence of fistula. The head of the pancreas showed minimal induration. There was no evidence of fat necrosis.

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The operative findings substantiated the radiographic findings of regurgitation of barium through the sphincter of Oddi.

Halligan and Baber[1] described one patient with regurgitation of barium through an incompetent sphincter. They attributed the finding to chronic pancreatitis. Kettunen[2] reported a case of reflux of barium into the biliary ducts. Sedlack and co-authors[7] found that 25 per cent of their 74 patients had a fistula at operation. They postulated that choledochitis and incompetence of the sphincter were related to cholecystitis and cholelithiasis. Scott[6], in a review of 181 cases, attributed 25 cases to regurgitation through the sphincter. In his own series, he reported six as due to regurgitation. Poppel[5] is widely quoted, and a recapitulation at this time seems in order. The authors prepared a table of the commoner causes producing an incompetent sphincter of Oddi with air, gas, or barium in the biliary tract without fistula formation. These include:

1. Adhesions producing traction on the sphincter
   a. Following surgery in the region
   b. With intra-abdominal abscesses
   c. With pancreatitis
   d. With perforated duodenal ulcer
   e. With cholecystitis and pericholecystitis
2. Tumors producing induration of the sphincter and thus keeping it patent, temporarily at least (pancreatic, gastric, colic, and Vaterian).
3. Marked antiparistalsis of the duodenum.
4. Patency of the sphincter of Oddi following passage of common duct stones (patulous sphincter).
5. Disturbances of the innervation with dilatation of the sphincter (this is questionable).
6. Biliary tract infections (non-ascending).
7. Drug effects.
8. Ascending gas forming infections.

Physiologically and mechanically, the flow of bile into the duodenum is regulated by the sphincter. When the sphincter is contracted, bile is retained against the secretory pressure of the liver. When the pressure in the common duct exceeds 80 millimeters, the bile flows back into the gall bladder where it is concentrated. The sphincter is mainly under hormonal control. Cholecystokinin is released when food reaches the duodenum. Nash[4] has shown that persistent infection in the common duct (even after cholecystectomy or choledocotomy) may result in biliary obstruction from inflammation and fibrosis of the sphincter. Lempke[3] described 8 patients in whom the sphincter was sectioned or resected. He mentions two cases in which incompetence of the sphincter was noted. The present patient did not have a sphincterotomy, and this possible cause can be eliminated.

Summary

Incompetency of the sphincter of Oddi, or regurgitation of barium through the sphincter, is an uncommon but important radiographic finding. A case is reported with the etiology open to conjecture but related to the known cholecystits and cholelithiasis. Brief mention is made of several bibliographies in the literature.

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97 Rutland Road

How do streptococci initiate the chain of events that leads to rheumatic fever? A third year medical student here suggests an answer.

Rheumatic Fever: A Post-Streptococcal Hypersensitivity

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Rheumatic fever has puzzled the medical world for centuries. Although classified as a collagen disease and well known in its clinical manifestations, the etiology remains an unanswered major medical problem. Many theories have been proposed to explain the cause of this tragic disease. During the 18th century, internal manifestations of "venereal warts" were blamed; increased serum lactic acid, uric acid, and many other equally preposterous causes were theorized. In 1895, Newsholme[1] observed that rheumatic fever (in epidemic proportions) was usually preceded by sore throat infections. He considered the disease due to a saprophytic organism of low infectivity which concentrated about the joints and on occasion became parasitic.

Since then many more theories have been proposed and many more organisms implicated. From this confusion arose the theory that rheumatic fever was a post-streptococcal hypersensitivity.

Allergy as a cause of rheumatic fever was postulated early in the century by Weintraub[2], Swift[3], Zinsser[4], and other investigators. The idea eminated from von Pirquet[5] and Schick[6] who showed that serum sickness was due to a hypersensitivity reaction and that definite lesions occurred due to this phenomenon. But, because of the observations that rheumatic fever was usually preceded by an upper respiratory infection, it was felt that a bacterium must have had something to do with the eventual pathogenesis.

For centuries it has been observed that acute rheumatic fever may follow an acute upper respiratory infection. Sydenham[7] was apparently the first to note this phenomena. In 1880, Fowler[8] reported well documented cases of rheumatic fever that had recently recovered from an episode of tonsilitis or pharyngitis. During the early part of the century many workers implicated the streptococcal organism; but it was not until Lancefield's streptococcal antigenic classification[9] that the focus of study fell mainly on group A hemolytic streptococci.

The evidence implicating streptococci as the major, if not the sole, cause of rheumatic fever is now quantitatively quite impressive and qualitatively conclusive, although by indirect means. Evidence has been accumulated in four areas of investigation: clinical, immunologic, epidemiologic, and prophylactic. Clinically it is well known that rheumatic fever follows upper respiratory infections caused by streptococcal organisms.

* Mr. Marcus is a third-year student at the Temple University School of Medicine.

Immunologic evidence was needed to substantiate the theory that streptococcal infection precedes acute rheumatic fever. In 1932, Todd[10] studied methods for titrating antistreptolysin in serum. This brought forth a wealth of serologic evidence documenting the frequency of preceding streptococcal infection in attacks of rheumatic fever. Many other antigenic products of the streptococcal organism have since been found to have specific human serum antibodies directed against them. These are hyaluronidase, fibrinolysin, DNAase, and DPNase. Detection of these antibodies in the serum of patients now makes the diagnosis of a streptococcal infection highly accurate and efficient. Nearly all recurrent, as well as initial, infections can now be diagnosed. Thus, it has been possible to find evidence of streptococcal infection in virtually all rheumatic fever patients. (Goldberger[3])

Epidemiologically, it is noted that about 3 per cent of those who develop streptococcal infections will eventually get rheumatic fever. (Rammelkamp[11]) Rantz[12] studied nearly 1300 respiratory infections and found that among the 900 cases *not* caused by group A hemolytic streptococci, there was no rheumatic fever. In the remaining 400 cases demonstrated to be due to group A streptococci, 19 were complicated by rheumatic fever[12].

Proper control and treatment of streptococcal infections will reduce the incidence, morbidity, and mortality in rheumatic fever patients.

Since the streptococcal organism was shown to be intimately related to rheumatic fever, and since rheumatic fever is considered a collagen disease, we must consider how the organism damages connective tissues. Streptococci can damage body tissue through three mechanisms:

1. The direct effect of living streptococci
2. The toxic effect of streptococcal products.
3. Immunologic technics

Rheumatic lesions are non-pyogenic and bacteria free. They do not resemble lesions produced by exotoxins. But the lesions are compatible with an allergic reaction (Long[14]).

Also, in diseases of known bacterial etiology, the incubation period is much shorter than that observed in rheumatic fever appearing after a streptococcal infection. This lag suggests a period of sensitization. Other evidence indicating an allergic phenomenon is furnished by Murphy and Swift[15]. They repeatedly sensitized rabbits with different types of group A streptococci producing lesions resembling those of rheumatic fever. The incidence of the lesions was nearly the same as the incidence of rheumatic fever in a population infected with group A streptococci. Furthermore, ACTH and adrenal cortical steroids beneficially affect acute attacks, suggesting interference with an allergic reaction (Robbins[26]).

Believing that rheumatic fever is a hypersensitivity state following a streptococcal infection, investigators have searched for the antigen (allergen) involved in production of this state. It was logical to study the antibody response of the rheumatic individual to various streptococcal products, in hope that an exaggerated atypical response might be observed.

Swift[16] reported that in the rheumatic patient there was a greater production of antibodies to streptolysin O, to streptokinase, and to hyaluronidase, as compared with a non-rheumatic patient. He concluded that there was a tendency in the tissues of certain individuals to over-react to the streptococcal infections which eventually resulted in rheumatic fever lesions[16].

McCarty[17] also related the antibody response to streptococcal products, as a possible mechanism for the pathogenesis of rheumatic fever, because the rheumatic patient showed a greater response in producing complete antibodies to streptococcal antigenic products. He contended[17] that the lag time between streptococcal infection and the appearance of rheumatic symptomatology is approximately equal to the time necessary for the production of antibodies.

However, when rheumatic subjects have been tested carefully with quantitative immunologic methods (following injections of various purified non-streptococcal complete antigens) there have been no constant qualitative or quantitative differences in their formation compared with the antibody response of non-rheumatic patients. It could then be said that the high level of streptococcal antibodies formed in acute rheumatic fever simply is evidence of repeated or intense streptococcal infection (Stollerman[18]).

A characteristic feature of an antigen-antibody reaction is specificity[19]. It has now been established that the basis of type-specific immunity in man is due to the production of type-specific antibodies by the M protein cellular component of group A streptococci. Therefore, the antigenic substance responsible for the hypersensitivity should be specific for a serologic type group A streptococcus, rather than a substance which is common to the group A streptococci in general. Thus, the type specific M protein of the streptococcal organism may be responsible, as this substance is also believed to be important to the streptococcal organism in its biologic relationship to virulence. (Lancefield[20]).

Goldberger[19] believes this is the antigen responsible for the antigen-antibody reaction of rheumatic fever. But, Murphy and Swift[15] have produced myocardial lesions with damage to collagen tissue by repeated injections of a number of types of group A streptococci into rabbits. Therefore, the specific antigen seems not to be limited to any particular type of group A streptococci.

If one accepts Stollerman's statement[18] ". . . that rheumatic patients have little if any hyperreactivity to known streptococcal antigens . . .," the study of complete antibodies formed in response to these antigens in trying to uncover the etiology of rheumatic fever seems useless.

However, it has also been shown that incomplete antibodies are an important factor in the origin of allergic diseases (Coca and Grove[22], 1925; Miller and Campbell[23], 1947; Kuhns and Pappenheimer[24], 1952). Wagner and Rejholic[21] are apparently the first investigators to implicate this phenomena of incomplete antibody formation with the etiology of rheumatic fever. It was their purpose to discover whether rheumatic patients develop incomplete antibodies and whether there was any discernible hyper-reactivity in the formation of such incomplete antibodies in these patients.

Brucella abortis was used as the antigenic stimulus, and titers of normal agglutinins, as well as incomplete antibodies, were observed in a group of rheumatic patients and a control group of healthy individuals. All subjects investigated were of the same age and lived under the same environmental conditions. The results were:

1. The rheumatic patient developed antibodies a little faster than normal persons;
2. A small but statistically significant difference in titers of normal agglutinins was found between the two groups;
3. There was a substantially higher level of incomplete antibodies formed by the rheumatic fever group; and
4. Some controls showed an unexpected rise in titer compared to other members of the group.

The investigators thought that these observations gave further support to the hypothesis that the origin of rheumatic fever was allergic. They were also interested in those controls showing an unexplained rise in titer, for they may have been protential rheumatics.

To discover whether these immunologic hyperreactors were potential rheumatics, Rejholic[25] immunized a homogeneous group of subjects without any signs of rheumatic disease. The same antigen (Brucella) was used, and the titer of incomplete antibodies was obtained. The degree of sensitivity was compared with the incidence of sore throats and rheumatic fever. The results were:

1. The incidence of sore throat was not dependent on the grade of immunologic reactivity;
2. The correlation of immunologic reactivity with incidence of rheumatic fever was highly significant;
3. All of the subjects who became ill with rheumatic fever were good producers of incomplete antibodies, most being extremely good producers.

Hence, Rejholic[25] suggests that an exceptional reactivity or hypersensitivity in the host appears to be the primary factor associated with the pathogenesis of rheumatic fever. However, before any of this work can lead to the etiology of rheumatic fever, one must trace the incomplete antibodies to streptococci and to tissue antigens which may develop naturally in the rheumatic subject.

The lesions produced in rheumatic fever are presumably due to a post-streptococcal hypersensitivity that effects the collagen tissues of the body. Many immunologic technics have been used to produce connective tissue damage, in an effort to implicate one in the pathogenesis of rheumatic fever. Some of the hypersensitivity reactions that have been hypothesized to be related to the etiology of rheumatic fever are: anaphylaxis, Arthus reaction, tuberculin type of delayed reaction hypersensitivity, auto-antibody, and the Shwartzman phenomena.

The anaphylactic phenomenon as the cause of rheumatic fever is hypothesized by Goldberger[19]. By enumerating clinical similarities between rheumatic fever and serum sickness, he suggests that the two are similar but not identical. He believes that they differ in the fact that rheumatic fever is caused by an antigen-antibody reaction plus another factor which is possibly a re-infection with a specific serologic type group A streptococcus.

The Caveltis found that rats given injections of streptococci plus extracts of rat heart, skeletal muscle, and connective tissue developed antibodies to the respective tissues as measured by a colloid particle technic. Lesions resembling those of rheumatic fever appeared on the valves and other connective tissue structures of the heart. Also, in rats focally injected with group A streptococcal autogenous tissue, auto-antibodies to rat tissue were found. The Caveltis propose this mechanism of auto-antibody reaction "that streptococcal prosthetic groups unite with connective tissue protein to create an antigen that evokes antibodies to the streptococcal-connective tissue protein complex. These antibodies then produce an immune reaction in connective tissue with the production of focal areas of allergenic necrosis."[26]

Production of the generalized Shwartzman reaction in rabbits infected with streptococcus, using S. marcescens toxin as the shocking dose, has been observed. None, or very few, renal lesions were produced, but many significant cardiac lesions were evident. These lesions were not identical with rheumatic carditis, but Thomas[27] believes the phenomena may have advantages as a working model for rheumatic fever problems. He[27] feels that for this to be meaningful, an event in rheumatic fever equivalent to the intravenous injection of bacterial endotoxin must be found.

Another study has developed from the thesis that new substances might arise from the interaction of the streptococcal and host tissues which might serve as the irritants in the pathogenesis of rheumatic fever. In this study, a soluble substance was extracted from group A streptococci lesions in the skin of rabbits which were effective in preparing rabbits for the generalized Shwartzman reaction. The shocking reaction could be caused by reduced filtrates of group A streptococci which contained streptolysin O[28]. The investigators responsible for this work believe that since rabbits can be prepared and provoked for the generalized Shwartzman reaction with factors derived from group A streptococci this adds significance to the possible role of this reaction to the etiology of non-suppurative sequellae associated with group A streptococci infection.

Long[29] has suggested a hypersensitivity of the tuberculin type to streptococcal allergens as another post-streptococcal state that may be responsible for rheumatic fever. He has observed that in the guinea pig, cells damaged by a specific streptococcal toxin are more susceptible to bacterial allergens than cells not so damaged, and this may in part explain the role of streptococci.

The presence of living streptococci is necessary throughout convalescence for the development of rheumatic fever. This observation suggests a hypersensitivity of the tuberculin type being involved in the pathogenesis of rheumatic fever.

Today, investigators are implicating delayed type hypersensitivity, more than other mechanisms, as the cause of rheumatic fever. Tuberculin type sensitivity can be induced in man and animals by almost any type of protein. Spontaneous sensitization of this type occurs regularly in streptococcal infections.

Similarities between the delayed reaction hypersensitivity and post-streptococcal states are noted:

1. The nature of the antibody involved is still unknown.
2. Both are slow in their reaction with tissues.
3. Necrosis and induration of tissues involved occur in both.

The dramatic response of rheumatic fever to ACTH and cortisone supports the allergic theory. Herbert[30] and others have suggested that these hormones do not inhibit allergic reactions caused by classical complete antibodies, but that they do affect allergies caused by tissue fixed antibodies and atopic reagins. This further suggests delayed type hypersensitivity and rules out many previously theorized mechanisms involving classical complete antibodies.

Florio, Weiss and Lewis[31] tried to demonstrate a cellular hypersensitivity existing in rheumatic fever by means of tissue culture. Both white blood cells and human fibroblasts of rheumatic and non-rheumatic patients were compared in their responses to streptococcal filtrates and disintegrated streptococcal organisms derived from strains known to cause rheumatic fever. No delayed hypersensitivity of the tuberculin type could be demonstrated with the white blood cells; and if a cellular hypersensitivity to streptococcal antigens does exist in fibroblasts of rheumatic patients, the results indicated a subtle rather than a striking phenomenon. The investigators concluded that a statistically demonstrable hypersensitivity may exist in rheumatic fever, but, an individually measurable one did not exist under their experimental conditions.

Conclusion

There is evidence in favor of a preceding group A hemolytic streptococcal infection initiating the chain of events in rheumatic fever. But more information is needed to explain the phenomena following the initial infection and eventuating in the clinical entity: rheumatic fever. Although much information has been accumulated in the attempt to call rheumatic fever a "post streptococcal hypersensitivity," it is also obvious that an absolute answer is still impossible. There is much more to be proved before the complexities involved in the etiology of rheumatic fever are understood.

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16 Ross Road

Physicians have not really lived up to their responsibilities in trying to help the retarded child and his parents. This thoughtful presentation by an internist highlights some of the problems.

An Internist Looks at Mental Retardation

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Upper Saddle River

The vastness of the problem of mental retardation can be visualized by statistics involving cost and numbers involved. Depending on the article quoted, 3 per cent of the national population representing 5 million mental retardates[1] exist today. Some 4 per cent of these are confined to institutions with an annual budget of 300 million dollars. The total cost to the nation (including new facilities under construction and special care in the family home) is about a billion dollars a year. These unfortunate increase at the rate of 100,000 per year. The problem is obviously one of national concern.

The writer is employed on a part-time basis as Director of Medical Education at the North Jersey Training School in Totowa Boro; this is one of several institutions maintained by the State for the care of mental retardates. It consists of 26 major buildings on 245 acres housing 1,050 residents. Most of these are housed on the main grounds consisting only of females, ranging in ages from 4½ through 73. Younger children (a mixed group of males and females) are housed in a large nursery unit. Overall, the institution contains 210 mongoloids, 64 cerebral spastics, 199 orthopedic problems, 197 convulsives, 77 psychiatric disorders, 42 cardiovascular diseases, 231 (of the main campus) ocular refractive errors, and 14 cases of arrested pulmonary tuberculosis. Most of these are multiple rather than singular defects.

*The views expressed by the author do not necessarily represent the policy of the Department of Institutions and Agencies of New Jersey.

Admission Procedure

Because of the long waiting period prior to admission, the inmate has usually been evaluated thoroughly at another institution. These records are available to us. The parents, or next of kin, accompany the inmate during the admission procedure, so that a further history may be elaborated. A standardized form is used which has been elaborated upon during the years with subsequent changes made as conditions change. It is complete but readily usable. A preliminary physical examination is made. Occasionally, an immediate diagnosis can be obtained. Often, further studies are indicated before a final diagnosis can be resolved. The inmate is routinely admitted to the unit for one week. This is done to permit medical observation while routine studies (urinalysis, blood count, serology, chest, x-ray, stools for ameba and parasites, and inoculations) can be completed. If no further studies are needed, the inmate is then transferred to the appropriate cottage unit. Intelligence and age group usually determine the latter. The aspect of training, education, and final placement somewhat involves the medical service as most things do; but these are largely within the province of other departments and will not be elaborated upon further.

Medical Classification

Until recently, final medical diagnostic terms used by similar institutions have been confusing. The terms used, though correct, were so varied that statistical compilation of resident population was impossible. Recently a manual[3] on terminology and classification in mental retardation has been prepared and adopted by most states. It has helped all of us. Not only has it given the field new stature by virtue of consolidating current efforts and thinking, but it has helped us understand better the basic problem by correctly categorizing the inherent defect. Classification then becomes simplified, and statistics more accurate. This is important because the problem of mental retardation is being vigorously attacked by multiple groups in both basic and applied research[4]. Admittedly, knowing the amounts and types that one is dealing with does not make the problem any less insurmountable; but at least it makes one aware of where to apply maximum effort. A case in point is the listing of chromsomal abnormalities in relation to mental deficiency[5]. Here the listing is large but the ratio small, when one looks at the grouping of cultural-familial mental retardation, where the bulk of our inmates fall. It is then obvious that a major effort should be directed at the latter in the hopes of not only reducing its bulk but categorizing it further so that finally it may be eliminated entirely.

Medical Care

From a medical standpoint we can approach the problem along three planes: the parent, the child and the diseases involved.

The Parent: From an initial state of confusion, shock, and refusal to accept the final verdict of mental deficiency, the parents react with shame, a guilt complex, bitterness, envy, over-protection or rejection[6]. From this stem three basic interactions between the institution and parents. Two are rather difficult, sometimes impossible to deal with. These are the parents who either completely reject the child or those with guilt and over-protective feelings. The former do not do enough; the latter do too much and obstruct. There is the third and—I think—rational parent who realizes the problems involved and tries to do something about them. From these have come the varied parent groups who have been so vital to our progress over the last decade. They have given time, effort, and energy in every conceivable fashion to help, as a group, the field of mental retardation.

The Child: Kushnick[7] says that these children can be approached when ill like any other ill child and treated accordingly. Basically, this is true; but it is not quite as simple as it sounds. Multiple problems are involved before actual therapy can begin. One gleans a history from a variety of sources; i.e., the attendant, the nurse, former or current illness, and the child, if possible. It is difficult to get a history from a mentally deficient child. The child may react to illness not unlike stroke victims, exhibiting primarily panic, fright, and unreasonable fear[8]. In addition to this emotional overlay, there is a problem in communication. As a group, 75 per cent are mildly retarded, 20 per cent are moderately so, and 5 per cent are severely incapacitated[9]. Practically no help can be obtained from the latter two categories, necessitating other sources of information. This applies to the physical examination as well, since reasonable cooperation must exist between examiner and patient. These factors handicap the physician, since he then must rely basically on laboratory and x-ray criteria. As a group, I think, most physicians use the latter to corroborate rather than make a diagnosis. Unfortunately, this is sometimes the only avenue of approach we have. And, of course, there are basic problems in *treating* mental defectives.

The Diseases Involved: Though the overall common denominator is mental deficiency, there are certain basic diseases associated with this disorder, such as convulsive seizures, cerebral spastics, ocular abnormalities, congenital cardiacs, incontinents, contractures, personality and emotional problems, and those diseases common to the young and old alike, communicable diseases.

Those diseases which we physicians consider as normal childhood ailments, and part and parcel of growing to adulthood, are notorious killers of our resident population. Measles is a case in point. Approximately every third year, an untapped reservoir accumulates, ignites, and then involves all non-immune inmates regardless of

isolation or gamma globulin. The end result is an immune population, but at a cost of eight or nine deaths. With the availability of a live, attentuated, measles vaccine in conjunction with gamma globulin, we hope to obviate this in the future.

Another formidable disease, not usually seen in general clinical practice, is amebiasis. This has plagued our institution since its inception. It is endemic despite isolation, prophylactic or active therapy, new drugs, or new procedures. We feel that this will remain so until the day arrives when *trained* personnel care for our inmates.

We have run the gamut in therapy, but eventually our preference has resolved to a combination of oxytetracycline† and di-iodohydroxyquin†.

We have never had liver involvement, hence do not use chloraquine†. Emetine we still find as a useful drug initially to control diarrhea.

Of lesser import, but still as troublesome to us as in private practice, is infectious hepatitis. Our incidence is normal for the area involved, but the problems involved are extensive. Our tightly knit little community is like a single large family. But managing it this way may not be practical for many reasons, notably cost. It's rather impractical to inoculate 1050 inmates and some 360 workers with gamma globulin. We have resorted to the cluster immunization technic which has, so far, been most successful.

Psychiatric Aspects

I am reluctant to discuss this phase of mental retardation, because of my lack of training in psychiatry. However, as elsewhere, problems do exist primarily because of the lack of interest by the practicing psychiatrist. This is not a criticism as such but a simple fact. Dichter[10] states that "psychotherapy with the retarded child can be successful; yet we should also be aware that our present therapeutic and diagnostic methods still require considerable experimentation and research." For effective rapport to exist between therapist and patient, some degree of intelligent communication must exist. With an I.Q. of below 50, this ceases and the therapist is hamstrung. Recently our institution (and this is not a new approach) has attempted group therapy. We have been delighted with our results and plan further development of this modality.

We have our share of emotional disorders. It is sometimes impossible to determine whether the emotional factor is or is not primarily responsible for the retardation. Probably the single most important advance in this area has been the availability of tranquilizers. They do not solve the basic problem; but they make our lot a bit easier. It is rare today to see the violent outbursts that existed prior to the development of tranquilizers. A rough estimate of the vastness of this problem is the proportion of our drug budget spent on these drugs. The ratio is approximate 25 per cent, but, may I add, worth every penny of it.

Rehabilitation

In this area, work in our institution has been scant. Many of our patients need orthopedic, physiatric, and physiotherapy. Our aim is total rehabilitation, both mentally and physically. Training is one phase where we have made tremendous strides. Unfortunately, the physically handicapped has been the step-child of this program. Without the physical means to compliment mental improvement, some individuals are relegated to institutional life and become an increasing burden not only to themselves but to all of us. This, we hope, will change as more moneys and personnel become available.

Conclusions

1. Most mentally retarded need not be confined in institutions.
2. They have no more criminal tendencies than the rest of us; probably less.
3. They are not predetermined sex delinquents.
4. They can be trained and educated[11].

† The brands we used were tradenamed as follows: Oxytetracycline as Pfizer's Terramycine; Di-iodohydroxyquin as Searle's Diodoquin; and Chloraquine as Winthrop's Aralen.

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The author here expresses appreciation to Virginia Shortman, R.N., Mrs. Mildred Jackson, and Dr. Dennis J. Buttimore—all of the North Jersey Training School, whose help was invaluable in the preparation of this article.

363 West Saddle River Road

Mechanisms of Extradural Hematomas.

The mechanisms operating in the development of extradural hematomas were investigated in dogs by introduction of a fluid pressure into the extradural space. By varying the input pressure and the size of the initial dura bone detachment, a critical force was derived which was deemed necessary for further dura bone detachment and clot propagation. The clinical picture here and that in another canine group in which an extradural mass of definite size was introduced were related to the pathological anatomy by obtaining coronal sections of the calvaria and contents after clot formation. These results indicate that extradural clots are arterial in origin, require a small performed extradural pocket for development, and accumulate within several minutes after arterial laceration, and that uncal herniation is responsible for the rapid clinical deterioration even though in certain individuals a sizeable amount of uncal herniation can be well tolerated.

L. E. Ford and R. L. McLaurin

J Neurosurg 20.760 (Sept) 1963

Progressive Lipodystrophy.

A clinical study of 50 patients with progressive lipodystrophy at the Mayo Clinic is presented. Evidence gathered from initial and follow-up data revealed that the lipodystrophic process continued over a period of 1½ to 6 years. It was confined to the part originally involved in about half of the patients and extended to other regions of the body in the others. The characteristic adiposity of the pelvis and lower extremities was observed only in postpuberal females. Growth, sexual development, and reproductive ability were not influenced by the lipodystrophy. No familial incidence could be discovered. The relatively frequent observation of an acute febrile illness preceding the wasting was of interest. Functional complaints and psychic disturbances were not frequently. Some evidence favors the possibility of primary disease affecting the nervous system at a central level as a cause of progressive lipodystrophy.

J. R. Poley and G. B. Stickler

Amer J Dis Child 106:356 (Oct) 1963

New Jersey physicians are here reminded that even tropical diseases may occur in our state.

Lepromatous Hansen's Disease

Albert L. Rosenthal, M.D.
Thomas K. Rathmell, M.D. / Trenton

The diagnosis of Hansen's Disease must be considered even in atypical regions. This case is reported because: (1) The diagnosis was not entertained for seven years during which time this patient lived in close contact with five children in two families. (2) Severe problems in therapy were encountered—a lepra reaction was exacerbated following initial DDS therapy. (3) Her skin lesions were teeming with closely packed masses of lepra bacilli lying in bundles and in globi. (4) The decision to administer BCG to convert to positive lepromin reactions the exposed children with negative lepromin tests was a difficult one, and the results only partially successful.

A 42-year-old Negro was first admitted to the Mercer Hospital, Trenton, N. J. for gastrointestinal difficulties. She was discharged nine days later and asked to return for a biopsy and special stains. Instead, she spent the following six weeks working as a domestic in Bermuda. Three months after her first admission, she returned to the office and was admitted to Mercer Hospital with a diagnosis of lepromatous Hansen's Disease.

On admission to the hospital she was depressed, lethargic, and complaining of severe generalized pain, worse in the hands and forearms, with malaise and marked edema of the hands and feet. She had granulomatous, hyperpigmented, indurated, sharply marginated papules and plaques, with irregular to serpiginous borders over the face and neck (worse on the right side), earlobes, nose, forearms, hands, and lower extremities, especially the toes. Firm, tender, violaceous nodules, and edema of the anterior legs were present, as well as plantar and palmar scaling and plantar hyperkeratosis. There was a suggestion of a right facial weakness, conjunctivitis of the right eye, induration and thickening of both ear lobes, an inflamed intact nasal septum, and decreased lateral eyebrow hair. There was marked hypesthesia and hypalgesia of the right forearm and hand and both ankles and feet, accompanied by a loss of sensation to temperature in these areas. Biopsy (to Dr. Richard B. Stoughton, Western Reserve Pathology Dept.) and skin and nasal scrapings (to Dr. Thomas K. Rathmell, The Mercer Hospital) revealed on acid-fast stains bacilli present in great numbers with *globi* and *cigarette-pack forms*. Numerous reticulum cells and pigmented histiocytes were also present. The leucocyte count was 8,600 with 77 per cent polymorphonuclears; hemoglobin 12.8 grams; red cells 4.57; color index .94; BUN 17. Stools were negative for ova and parasites; KOH fungus preparation from soles, negative; x-ray of chest, foot, skull, and arm was negative. Lepromin testing was negative for both the Fernandez and Mitsuda reactions.

The patient is a native of Costa Rica. While working in a hospital there seven years prior to present admission, she noted a hypopigmented lesion of her right cheek. This resolved, but other hypopigmented lesions of the arms and face appeared in the next four years. Six years later she noticed these depigmented macules on the right hand, arm, face, and feet. These lesions became tender, pruritic, hyperpigmented, and indurated. In addition, for five years she has had severe earaches, increasing in frequency and degree. Over the years she had several examinations and once, at a large Eastern Medical Center, a biopsy was reported consistent with mycosis fungoides. She received triamcinolone therapy for six months. She began at this time to note that in these areas she had lost the sensation of pain and touch.

She agreed to go to the National Leprosarium at Carville, Louisiana. However, administrative difficulties in arranging the transfer to the government hospital were encountered. Because of her severe pain and discomfort, and because her skin lesions were extending and becoming inflamed, it was necessary to start therapy in New Jersey.

On the advice of an Indian leprologist (visiting in the U. S. A. to attend the International Congress of Dermatology), she was placed on Dapsone® (diaminodiphenylsulfone) 100 milligrams a day. In addition, because of concomitant urinary infection, she was placed on Declomycin® 150 milligrams four times a day. Synalar® cream was prescribed for the skin lesions. After two weeks, her course became stormier. She developed fever (up to 103), chills, nausea, and vomiting, with increased inflammation of the involved skin lesions. It was felt that this accentuated lepra reaction was due to too vigorous initial dosage of Dapsone®, and she was taken off this and given intramuscular injections of Upjohn's Depo-Medrol®. This was repeated on three occasions, three days apart, and her fever subsided with general improvement. Three weeks later, she was transferred to the U. S. Public Health Service Hospital at Staten Island for eventual transfer to Carville. On the day of transfer, her temperature again rose to 101.

Although seldom encountered in New Jersey, Hansen's disease is occasionally seen in eastern cities with large numbers of recent arrivals from Puerto Rico, Latin and Central America. In a six-month period, three previously undiagnosed cases in the Delaware Valley area (central New Jersey[1] and Philadelphia) were encountered. These occurred in individuals from India, Puerto Rico, and Costa Rica. The increased use of air travel will bring more exotic conditions into areas where they are usually not considered. This patient had been intensely studied at a large eastern diagnostic center in addition to numerous other consultations. Once we had established the diagnosis of Hansen's disease and hospitalized her, various other problems arose.

In retrospect, it appears that the initial sulfone therapy was too vigorous. However, Lowe[2] has stated that DDS is effective in the smaller dosages (under 200 milligrams) daily. If this dosage is not exceeded, untoward effects are rare. Lowe[2] prescribes a maximum standard daily dose of 200 milligrams by mouth, or 400 twice a week. He feels that complications are fewer with the latter and believes that the minimum active dose may be as low as 30 milligrams. Cochrane[3] commences DDS therapy with 25 milligrams orally twice a week, and gradually increases to a maximum of 400 milligrams twice a week. Other sulfones (Diasone®, Sulphetrone®, Promizole®, and Promacetin®) have been used with considerable success, but it is interesting that in the chemotherapy of leprosy, there has been a return to the parent sulfone[3], 4,4 diaminodiphenyl sulfone (DDS)[4]. Since the disubstituted sulfones probably act only through their degradation to DDS following their oral administration, it seems logical to use DDS[5].

Allday and Barnes[6] have differentiated a DDS syndrome from the lepra reaction. Lepra reactions following DDS therapy are of the type seen in leprosy in its natural course. These vary from mild fever with aggravation of existing skin lesions to severe episodes of high fever, inflammation, necrosis, and extension of existing skin lesions, the appearance of new lesions (especially nodules on the outer borders of the arms and legs in lepromatous cases), severe neuralgia, erythema nodosum, and occasionally erythema multiforme[7]. The majority of leprosy patients with or without treatment do have lepra reactions in the course of their illness.[8]

The DDS syndrome occurs in individuals taking DDS for five to six weeks when suddenly, "out of the blue", comes a violent illness. The presenting symptom of this is a papular or exfoliative rash. The rash may be confined to the upper limbs or forehead, or widely disseminated but sparing the scalp, palms, and soles. This exanthem may remain papular, or may fade and exfoliate. Fever, malaise, and weakness are present with the rash but do not precede its onset. Other systemic findings may include hepatomegaly, epigastric pain, lymphadenitis (notably along the posterior border of the sternocleidomastoid), and mononucleosis. After a week of severe illness, a gradual improvement is seen usually, with flattening of the leprous skin lesions temporarily. (Later reactivity of the skin eruption may occur.) Allday and Barnes[6] believed this to be a reaction of hypersensitivity because of the five to six week interval from the beginning of therapy. It is obvious that in our case the flareup was a true lepra reaction rather than the DDS syndrome. (Eventually, her lepra reaction was controlled with large dosages of Prednisone® after an unsuccessful nine-day trial of quinacrine (Atabrine®) at the Public Health Service Hospital[9].)

This woman had lived as a domestic in two homes—one for ten months, one for eighteen months. There had been almost constant exposure of two children in one family and three in another. Chung-Hoon[10] has reported on 316 new cases in Hawaii of whom one-third first reported symptoms before the age of twenty. In India[11], the incidence of leprosy in children exposed to lepromatous leprosy in their homes is 25 per cent. Lara[12], in the Philippines, found 200 cases of leprosy among 770 children between the ages of one and five living with their leprous parents. In our case, the family with the three children underwent lepromin testing which revealed that all were non-reactive. All three children received BCG vaccination. After this, one child showed a positive lepromin and tuberculin test, one a negative lepromin with positive tuberculin, and one remained negative on both.

Our patient presented with typical skin lesions of lepromatous Hansen's disease. However, Jonquieres and Caballero[13] have described a diffuse lepromatous leprosy which "is a grave contiguous form often passed over by both the patient himself and the physician who occasionally encounters it." They stress that it is possible to have mild changes without alteration in elevation, color, or skin texture. However, in advanced lepromatous leprosy, the nasal mucosa is almost always positive on scrapings. When positive, the number of bacilli in the skin are relatively large[14]. Jonquieres and Caballero[13] stress the importance of the Carville type of bacteriologic examination for acid-fast bacilli in lepromatous leprosy. This examination consists of a systematic search for bacilli in certain areas, symmetrically, taking scraped incision smears from the forehead, earlobes, cheeks, chin, forearms, elbows, abdomen, buttocks, thighs, knees, and legs.

Summary

This case presents some of the problems which result from the appearance of a common tropical disease in temperate areas where it is encountered infrequently. There occurred late diagnosis, delayed hospitalization, and treatment problems. A lepra reaction developed coincident with too vigorous sulfone therapy. The unusual situation was encountered for this area in which susceptible children lived in close contact with the patient. Such problems may well become more common because of increasing air travel.

This case was reported at a joint meeting of the section of Pathology of the Philadelphia County Medical Society and Philadelphia Pathological Society (May 9, 1963, Drs. Rosenthal and Rathmell). Also at the section on Dermatology and Syphilology of the New York Academy of Medicine (Nov. 6, 1962, Dr. James T. Hearin and Dr. Paul C. Cronce: Society Transactions, AMA Archives of Dermatology 87:6, June, 1963).

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724 West State Street (Dr. Rosenthal)

STATE ACTIVITIES

Trustees' Minutes

March 15, 1964

A regular meeting of the Board of Trustees was held on Sunday, March 15, 1964, at the Executive Offices. For the full information of the membership, detailed minutes are on file with the secretary of each component society. A summary of the significant actions follows:

Meetings of County Presidents . . . Directed that presidents of component societies be invited to hold an organizational meeting in Trenton on the day of the October 1964 Board meeting; that they meet with the Board in its afternoon session; and that the scheduling of future meetings be decided subsequent to this October meeting.

Membership Directory . . . Received a letter from Compos-O-List Systems indicating that it was no longer interested in producing the *Membership Directory* with advertising this year. This necessitates that the Society publish a *Directory* at its own expense.

Health Examination . . . Approved the recommendation of the Cancer Control Committee that all physicians and their wives have annual physical examinations on or near their birthdays.

Mammography . . . Approved the recommendation of the Cancer Control Committee that mammography *not* be used for cancer screening at this time.

Tumor Registry . . . Approved the recommendation of the Cancer Control Committee that another survey in New Jersey hospitals be conducted in 1964 and 1965, to determine the status of tumor registries.

Field Physicians . . . Approved the recommendation of the Maternal and Infant Welfare Committee that the State Health Department be urged to make mandatory (as part of the job as field physician) attendance at each annual meeting of the Medical Society's Committee on Maternal and Infant Welfare.

Maternal Death Statistics . . . Adopted the amended recommendation of the Maternal and Infant Welfare Committee—that all reports of deaths associated with pregnancy in any way be channeled, or reported to, the Maternal and Infant Welfare Committee for classification by the committee prior to being recorded by the Bureau of Vital Statistics.

JEMPAC . . . Granted the request of JEMPAC to sponsor a breakfast meeting during the May Convention in Atlantic City—to be under their exclusive auspices and independent and apart from the activities of the Society.

Per Capita Assessment . . . Adopted the following recommendations for referral to the 1964 House of Delegates:

1. That the House of Delegates approve a $5 per capita special assessment (for active and associate members alike) for 1965 in addition to, and not as part of, the budgetary assessment; and that both be paid at the same time.

2. That this per capita assessment be allocated as follows: 50% to be applied to the Society's Medical Student Loan Fund, 25% to be applied to the Society's bicentennial celebration fund (1966), 25% to be donated to the Academy of Medicine of New Jersey, to enable it to maintain its library services to New Jersey physicians.

Medical Service Administration . . . Approved the nominations as submitted by Medical Service Administration for membership on the Board of Governors as follows:

Irving P. Borsher, M.D.
Harry N. Comando, M.D.
Royal A. Schaaf, M.D.
Rudolph C. Schretzmann, M.D.
Edward W. Sprague, M.D.
John S. Thompson
Thomas J. White, M.D.

Blood Bank Commission . . . Approved the request from the New Jersey Blood Bank Commission for The Medical Society's annual appropriation of $250, to defray part of the expenses of the annual spring seminar.

Conference on Rheumatic Fever . . . Agreed to be one of the sponsoring agencies for the Upper Atlantic Regional Conference on Rheumatic Fever, to be held on April 27-28—under the auspices of the American Heart Association—with the understanding that no financial obligation is entailed.

Savings Account . . . Authorized the Treasurer to open savings accounts up to a maximum deposit of $10,000 at any New Jersey bank covered by the Federal Deposit Insurance System.

LETTERS TO THE JOURNAL

A Naive Evaluation

Dear Sir:

I refer to a paragraph found on page 9 of the January 1964 JOURNAL reprinted from the Cincinnati Journal of Medicine. The paragraph states:

"The drug industry is facing a critical period concerning research for new drugs. The physician should have available modern discoveries even though there may be side effects in some of them. The drug industry knows then they have discovered something beneficial for mankind. The thinking citizen of this country should not condone the 'whipping-boy attitude.' Politicians prey on people for votes. The pharmaceutical industry must stand on the merits of the products produced."

This strikes me as a dangerously confused and naive evaluation of what motivates the drug industry. Is thallidomide one of the modern discoveries which should be available to physicians even though there were side effects? You may recall that one of our drug companies was breathing hard down Dr. Kelsey's neck to have it licensed in this country because it had proved such a fine money-maker abroad. Immediately I think of other drugs such as Mer-29, Monase, Zoxazolamine-drugs which were licensed and subsequently withdrawn because of toxic side effects.

Too many inadequately tested chemical compounds are being thrust upon us with bally-hoo and formally engraved notices, and a year later, tail between the legs, are being withdrawn. I would urge a much more critical attitude on the part of physicians to new drugs than your JOURNAL does by reprinting this paragraph. I think that the drug industry has a very keen ear for what physicians would like to have at their disposal, and their advertising departments take it from there, although very few drugs really live up to their copy.

FRANCIS A. WOOD, M.D.
Newark

Distilled Water and Sugar Pellets

Dear Sir:

The sudden removal from the domestic market of Parnate® (tranylcypromine) by the manufacturer under duress by the Federal Drug Administration triggers this letter. This suppression was demanded because some 50 patients out of more than fifteen million to whom Parnate® had been prescribed had developed cerebral vascular complications; of these 50, fifteen died. So far as I can ascertain, there was no direct proof that Parnate® alone caused these complications or deaths; neither was it established that such complications would not have developed as a part of their ailments; nor was it recorded that Parnate® was not contraindicated in any of these cases because of features mentioned in the manufacturer's literature. So it would seem that we have here a case of "guilt by association." At 15 deaths amongst fifteen million patients, the association does not seem to have been "intimate." It is, I believe, akin to alleging that, if I professionally visited a certain female patient in January, I would necessarily be the father of her child born in the following October. And this suppression seems the more strange when we note that Great Britain and other foreign governments, viewing the same data, have not restricted the sale of Parnate® upon prescription.

This drug has enabled me, and many other physicians, to bring numerous patients out of acute depressive psychoses without any inadvertencies. This fact is disregarded by FDA, which tells American doctors that the only thing they can do with their decision is to "grin and bear it." I wonder? I had a patient under Parnate® and close to recovery when its sudden withdrawal stopped the therapy abruptly—and with regrettable results indeed. Decisions by FDA are not subject to any review. FDA also refuses to delay promulgation of its orders while a group of competent, disinterested experts submits its opinion. If this be not "Police State" action, then what is it? In this country we have had reliable, ethical, pharmaceutical manufacturers and competent laboratory and clinical product-evaluations since before you or I were born. Are we to accept that, quite suddenly and recently, these firms and these evalu-

ations have become untrustworthy and suspect? And am I to accept with equal suddenness and finality that I am no longer capable of prescribing what I deem best for my patients but must now ask FDA what I may, or must, use? With a bona fide medical license and diploma upon my wall and many years of practice behind me, this proposition is difficult to assimilate.

If decisions as to medicinal therapy are now to be made in Washington, then surely the time has come for laws which will grant immunity from civil suits for damages to physicians and drug manufacturers predicated upon alleged adverse effects of medicines dispensed to patients. Since such immunity would inevitably reduce the annual earnings of Mr. Belli and his confreres, it seems likely that he and his group will move either to have the law under which FDA operates declared unconstitutional, or to insert provisions therein making it possible to sue the Federal Government in such instances. And let us realize that, if it be the policy henceforth that any drug presumed to have produced some untoward effect in someone taking it shall forthwith be suppressed, it will not be long before pharmacies will contain only distilled water and sugar pellets. But, perhaps, not even these, for some foolish diabetic might guzzle a thousand sugar pills and thus go into coma; some idiot might imbibe several gallons of distilled water and develop toxic effects. The presumption is ridiculous that a potent drug can be entirely harmless and free of any possibility of side-effects. The presumption that only a federal agency or official can either test or evaluate a medicinal preparation seems asinine. But that is precisely what now obtains.

I fear that, unless physicians and their patients, pharmaceutical manufacturers and druggists (all of them voters and tax-payers) arise in conjoint protest at what now obtains and achieve remedial legislation, it will not be long ere we shall have lost all of our rights, freedoms, and privileges, and will awaken too late to a realization that totalitarianism has taken over the United States. There are many who believe that such goal is now being brought nearer, step by step. Those who would socialize (or sovietize) our country know that the doctors in private practice are their staunchest and most influential opponents, and that unless and until we be destroyed, or our independence and influence removed, they cannot attain their objective. So the job is being pursued in piecemeal fashion, whereby the real intention is not perceived by many; and so opposition is avoided, which would be invincible against an all-out frontal attack.

Anyone who would allege that pharmaceutical firms in this country are not concerned with the potency and safety of their products but care only about corporate profits either is in dire need of a psychiatrist; or has never visited a large drug manufacturing plant, and thus observed the programs of research, clinical testing, and quality-control; nor can he have knowledge of the huge sums won from drug firms in civil suits for damages brought under the doctrine of implied warranty of safety in their products, of which those manufacturers want no repetitions.

Is a dictatorial and unquestionable FDA essential to the survival of our citizens? If so, how do we explain the fact that they survived and multiplied for so many generations before such an agency was thought of? Can it be that our people—and you and I also—have but recently become so feeble and incompetent that we no longer can function upon our own in a democratic and free environment? I wonder what the eventual end of us will be, if we do not act now?

Albert G. Hulett, M.D.
Orange

BOOK REVIEWS

Nutrition In A Nutshell. By Roger J. Williams, D.Sc. Paperback. New York, 1962, Doubleday. Pp. 171. Illustrated. ($.95)

This paperback book is written for the layman. How many of them will understand the story which Roger Williams, a biochemist, is trying to tell is conjectural.

Dr. Williams is advertised on the cover as the "foremost authority on the science of nutrition." Of course, many prominent nutritionists are engaged in research and in the clinical approach to nutrition. It is difficult to say just who is the "foremost authority." However, Roger Williams is a good laboratory man and has a fine reputation.

This small book is packed with valuable information. His explanations on the need for nourishing the many tissues of the body, the content of nourishing foods, nutritional deficiencies, need for nutrition education, nutritional supplements, and good nutritional advice are timely and well done. He offers a list of names and, by implication, displays a directory to the public. This is not in good taste. While both the American Institute of Nutrition and the American Society of Biological Chemists are reputable organizations, a roster of their membership is of little value to the public. They are surely more interested in clinical practicing nutritionists whom they can consult for their problems than they are in a list of research workers.

Dr. Williams' claim that "nicotine poisons the appetite mechanism in such a way as to decrease the desire for food" is not true. Most of the obese patients I have treated smoke two or three packages of cigarettes a day without any effect on their appetites. Still, in the net, this book is well written and informative. It is a useful reference for students in nutrition.

S. William Kalb, M.D.

Practical Anesthesiology. By Joseph F. Artusio, Jr., M.D. and Valentino D. B. Mazzia, M.D. St. Louis, 1962, Mosby. Pp. 318. ($7.75)

"This book is designed for medical students and general practitioners as a handbook of current practices in anesthesiology. It will also be of value to the nurse anesthetist." This opening and restrictive statement of the authors is carefully adhered to throughout this book. It is plainly the authors' hope that, in addition, students and interns may be "stimulated to choose anesthesiology as their specialty and that the general practitioner may seek further training."

The chapter devoted to medical considerations will be especially helpful to the part-time anesthetists in avoiding pitfalls and complications of medical problems. Technics of clinical administration of nitrous oxide-oxygen, diethyl ether, cyclopropane, and thiobarbiturates are discussed in separate chapters to some detail. Readers seeking pearls of wisdom regarding halothane, chloroform, methoxyflurane, and other agents will be disappointed inasmuch as the authors do not consider these the safest available agents for the medical student or the general practitioner who only occasionally administers anesthesia. Guy Payne, Jr., M.D.

Mental Illness and Due Process. Association of the Bar of the City of New York with Cornell University Law School. Ithaca, New York, 1962, Cornell University Press. Pp. 303. ($5)

A committee of ten lawyers and three physicians report on their survey of the civil liberties of mental patients in New York State. In legal proceedings which lead to hospitalization, the committee complains that "no one represents the patient." They suggest a "review service" independent of the hospitals to keep constant vigil over patients' rights. How they will be appointed and how they can match their independence with their responsibility to the community is not clear.

Long-term patients, they suggest, should have hearings at least every two years. This is a noble idea. In the 15,000 bed Pilgrim State Hospital, that would require 7,500 hearings per

annum. With courts operating only 200 days a year, the hospital staff would be testifying in 37 hearings a day!

In spite of the committee's concern about patients' rights, they would encourage hospitals "to accept voluntary admissions without proof that the patient has legal capacity." They also suggest informal admissions—no formalities—no papers—no signatures! They recognize that even emergency commitments entail some red tape. The committee favorably quotes a judge who said that "where personal freedom is at stake, insistence upon literal compliance with the statute is essential". On the other hand another judge wrote "given symptoms of paranoia, the decision as to whether the patient is dangerous is for physicians to make. The courts cannot act as their own experts on these problems." They face up to the problem of transporting mentally ill patients to hospitals. They agree that there simply may be no alternative to transportation by the police—distasteful as this may be. (The alternatives would be use of trickery to get patient to the hospital; or to have doctors, nurses, or clerks use force.) In this connection, they report that most of a group of former patients said that the presence of police did not harm them. And some officials considered that the presence of marked cars and uniforms exercised a salutary symbolic effect.

The pros and cons of "hearing and notice" are reviewed. Should a hearing be held in the absence of the patient? Whether you say 'yes' or 'no', you can be in trouble, because of the traumatic effect of a hearing on some patients and the denial of civil rights implicit in any *in absentia* proceeding. "Yet", said the committee in one place (p. 188), "it is wrong to make all patients go through a hearing that is needed by only a fraction of them." Also, they agree that written notice to the patient "may be brutal and injects a note of accusation into what should be a purely medical procedure."

They favor allowing physicians on the payroll of public hospitals to sign certificates of commitment to their own hospitals. In rural areas, this prohibition restricts the usefulness of staff physicians to community agencies. The committee does not dispose of the counter-argument that a patient is usually hostile to a committing physician and that a change in the rule would impair the staff doctor's effectiveness.

The increasing use of tranquilizers among outpatients may, the committee fears, impose a problem too. "Tranquilizers", they say, "may reach the very source of the will to resist" and patients might let themselves be placed in hospitals because of a tranquilizer-induced placidity. Special attention, it seems, is needed to protect the rights of tranquilized patients.

Should patients be represented by attorneys? Physicians suggest that the attorney may be more interested in winning a case than in getting necessary care for a client. Lawyers also provide an unwelcome legalistic or criminal flavor.

The committee finds that 55 of 58 judges questioned thought that current statutes adequately protected the civil rights of patients.

The book deals almost entirely with New York procedures. Many of the references to the law are meaningless in other states. Their findings and recommendations are not readily translatable to the practice of other jurisdictions. However, the philosophic and ethical problems are the same everywhere. The committee presents a number of specific answers; and raises many challenging questions about this root dilemma of modern life: protection of the community versus the rights and dignity of the individual. Henry A. Davidson, M.D.

Doctors, Patients, and Health Insurance. By Herman Miles Somers and Anne Ramsay Somers. Abridged edition, paperback. Garden City, New York, 1962, Doubleday & Company, Inc. Pp. 544. ($1.95)

This is a detailed study of the organization, distribution, and financing of personal health service. It is confined to personal medical care only and was written with the hope that it would be useful to the variety of professional persons who work in and around medical care

—such as doctors, hospital administrators, insurance executives, administrators of employment health and welfare programs, labor and management negotiators and trustees, government officials, and other health personnel.

One section of the book is devoted to the changing methods of physicians' remuneration and attempts to standardize fees. Relative value fee schedules are discussed. The authors describe the battle over the corporate practice of medicine. The role of the drug industry is noted, including its influence on the choice of drugs used by the practicing physician. Also noted are some of the dangers resulting from this, and possible remedies.

The authors turn to the role of the third party as a means of paying medical costs. An analysis is made of private health insurance plans, medical care plans, and employment benefit plan programs. The desires of labor and management are reviewed. Various plans of health insurance are covered thoroughly, including group and accident health policies as written by commercial carriers, Blue Cross, Blue Shield, labor unions, major medical, and independent plans.

The authors examine in great detail the special problem of the aged. They appraise the solutions offered both by legislation and voluntary health insurance.

Part 6 of this book concerns the changing doctor—patient relationship. An attempt is made to identify a new type of relationship that appears to be emerging, primarily out of developments in modern medical service.

The book ends with a summary and conclusion reached by the authors. One must read this to evaluate it. Mr. Somers—who was a member of President Kennedy's Task Force on Health Care and Social Security—and Anne Somers—Consultant to the Social Security Administration—have offered a very lengthy dissertation on the subject of health insurance.

Ernest C. Hillman, Jr., M.D.

Synopsis of Obstetrics. By C. E. McLennan, M.D. St. Louis, 1962, Mosby. Ed. 6. Pp. 464 with 157 illustrations. ($6.75)

In 1949, J. C. Litzenberg wrote a compact manual of obstetrics for interns and general practitioners. The text achieved instant popularity and for almost a quarter of a century—and through five revisions—has remained a standard short manual. After Dr. Litzenberg's death, Professor McLennan took over the editing and revising of *Synopsis of Obstetrics.* This sixth edition is thoroughly up to date and clarified by many line drawings and several color illustrations. It covers both normal and abnormal obstetrics. The book is carefully dehydrated so that the author has no unnecessary words. While the treatment is, of course, not encyclopedic, it still remains one of the best small volume—useful to the medical student, the intern, the resident, and the general practitioner . . . And even the seasoned obstetrician can learn from it.

Victor Huberman, M.D.

Synopsis of Neurology. By Francis M. Forester, M.D. St. Louis, 1962, Mosby. Pp. 223. ($6.75)

Neurology lends itself well to diagrams, pictures, and drawings; but there is not a single illustration in this book. This small manual is beamed at the medical student. It tries to be compact without being sketchy, but the effort doesn't quite come off. For instance, the material on treatment is so brief and so thin as to lead the reader to suppose that neurologic disorders are untreatable. It is hard to believe that the author of this manual was also the editor of the helpful and hopeful Mosby text, *Modern Therapy in Neurology.* Medical students and general practitioners constitute the presumptive audience for this *Synopsis*—but when a neurology text does not offer a single electroencephalographic tracing, its value is questionable. The book may be useful to family doctors who want a sketchy account of a number of disorders, sufficient to give a simple picture of a lesion until the neurologist comes.

Herbert Boehm, M.D.

ABSTRACTS

ON TUBERCULOSIS AND OTHER RESPIRATORY DISEASES. ISSUED BY THE NATIONAL TUBERCULOSIS ASSOCIATION

MAY, 1964 • VOL. XXXVII, NO. 5

TUBERCULOSIS OF THE PERICARDIUM

A review of forty-four proved cases in a veteran population shows that medical treatment of this relatively rare form of tuberculosis is often sufficient, but surgery may also be indicated. Early initiation of treatment is of utmost importance.

Before the adoption of specific antituberculosis chemotherapy, tuberculous pericarditis carried a grave prognosis. Eighty to 90 per cent of those afflicted died in the acute phase, and many of the remainder subsequently died from constrictive pericarditis or from miliary tuberculosis.

For the study reported, the Veterans Administration in Washington, D. C., supplied a list of all veterans treated in its hospitals from 1952 through 1955 who had a clinical diagnosis of tuberculous pericarditis. The clinical records of 214 patients from all parts of the United States were collected and carefully reviewed. Forty-four cases had a positive culture or acid-fast bacilli seen in histological sections of the pericardial fluid or resected pericardium.

The average age at onset was 51 years, with a range of 20 to 66 years. Twenty-four patients were white, and 20 were Negro. However, since the ratio of whites to Negroes in the United States veteran population is 12:1, the disease was 10 times more prevalent among the Negro race.

Dyspnea on exertion or at rest was one of the earliest and most disabling symptoms. Less common and more gradual in development were ankle swelling and nonproductive cough. Chest pain, usually aggravated by deep inspiration, coughing or change in position, was variable in its nature, but rarely resembled angina. Generalized complaints of fatigue and anorexia were common.

Signs related to an elevation in venous pressure were also common. Pulse pressure was not significantly less than normal in the majority of cases, but it was rare to find a value greater than 40mm. of mercury.

Electrocardiographic tracings exhibited lowered voltages and 'T' wave inversion and were of considerable aid in the diagnosis.

In 10 cases a right-sided cardiac catheterization had been done. The pressures and their tracings were "consistent with" constrictive pericarditis.

Medical Treatment

In the group of 44 patients, 23 received medical treatment without subsequent operation. The medical regimens consisted of specific antituberculosis chemotherapy; pericardial paracentesis to obtain fluid for bacteriologic study and to relieve tamponade; and digitalization, diuresis, and a low-salt diet.

Streptomycin, para-aminosalicylic acid (PAS), and isoniazid were the only chemotherapeutic agents used. Duration of chemotherapy averaged eleven months for 11 patients who survived for five years and for 2 who died of unrelated causes. Early chemotherapy appears to be of paramount importance for a medical cure.

John H. Hageman, M.D., Nicholas D. D'Esopo, M.D., and William W. L. Glenn, M.D. *The New England Journal of Medicine,* February 13, 1964.

Eight patients died while receiving medical therapy. At the time of death all but 1 (who died two days after admission) were receiving antituberculosis chemotherapy. At autopsy all 8 had a thickened pericardium. Some of these pericardia were studded with caseous granulomas. The surfaces of the hearts appeared gray owing to a thickened epicardium.

Two patients probably died from the effect of cardiac tamponade. Another died of pulmonary edema after a bilateral thoracentesis, and one went into cardiac arrest after the paracentesis of both pleural cavities. Four others died as a result of chronic constrictive pericarditis.

Surgical Treatment

A pericardiectomy was performed in 21 patients after a period of medical treatment.

The indications for pericardiectomy were as follows: continued accumulation of a pericardial effusion; thickened pericardium (demonstrated by injection of air into the pericardial sac); calcification of the pericardium; results of pericardial biopsy; progression from larger globular heart in the effusion stage to a smaller heart with continued high venous pressure; and moribund patient with severe cyanosis and unobtainable blood pressure.

Thirteen patients have survived for five or more years after pericardiectomy. Two others are well after four and a half years. Another had a fatal gastrointestinal hemorrhage one year after pericardial resection.

Four patients died within thirty days of pericardiectomy, an operative mortality of 19 per cent.

The 11 patients who survived for five years or more have given no evidence of relapse or tuberculous pericarditis, nor has constrictive pericarditis supervened as a late sequela. This is one of the most important facts derived from this study: that early success of medical therapy results in control of the tuberculous infection, so far as control of infection can be assessed by an average follow-up period of seven and two-tenths years.

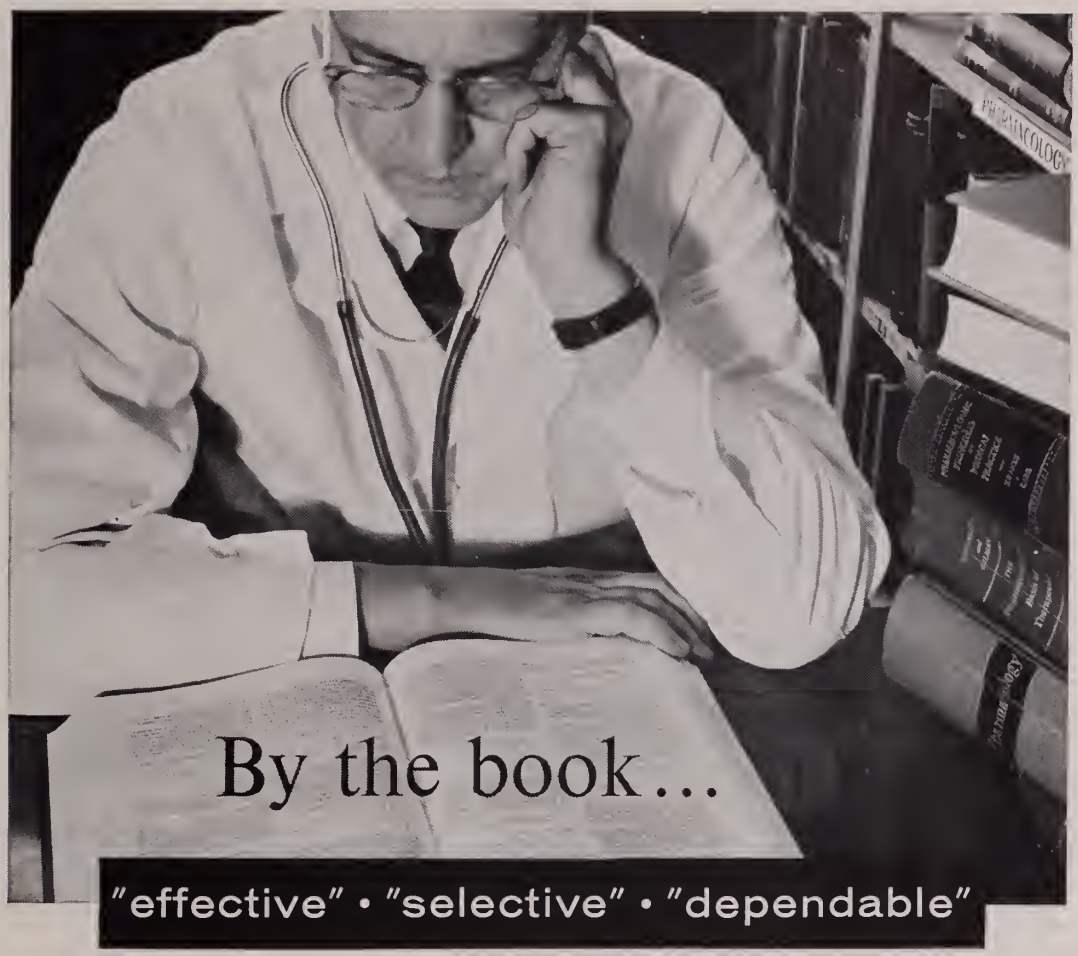
Conclusion

Several generalizations appear to be justified on the basis of this series. The early institution of chemotherapy increased the possibility of a favorable outcome of medical therapy.

The chronicity of pericarditis is the circumstance that most clearly calls for pericardiectomy. Pericardiectomy was superior to medical therapy alone in patients whose chemotherapy was begun late in their disease, as judged by symptomatology. Excellent results were achieved by pericardiectomy in 11 of 13 patients in whom symptoms of pericarditis had been present for more than six months before the pericardiectomy was carried out.

Treatment of tuberculous pericarditis should be started as promptly as possible with a regimen of two or more antituberculous drugs. The chemotherapeutic regimen should always include isoniazid. The total duration of chemotherapy should be at least two years under the most favorable circumstances, or longer, as indicated by tuberculous lesions in other organ systems if such lesions are present. However, tamponade severe enough to result in hepatomegaly, ascites or peripheral edema provides a clear indication for pericardiectomy. Pericardiectomy can safely be done through infected tissues under cover of antituberculosis therapy. Early success by both medical and surgical therapy may be counted on to give lasting control of infection; both modalities prevent constrictive pericarditis as a late sequela.

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[2] Plotz, M.: Modern Management of Obesity, J.A.M.A. *170*:1513-1515 (July 25) 1959.
[3] Bernstein, A. & Simon, F.: "Treatment of Obese Diabetics and Arteriosclerotics," Clin. Med. 907-920, May 1961.


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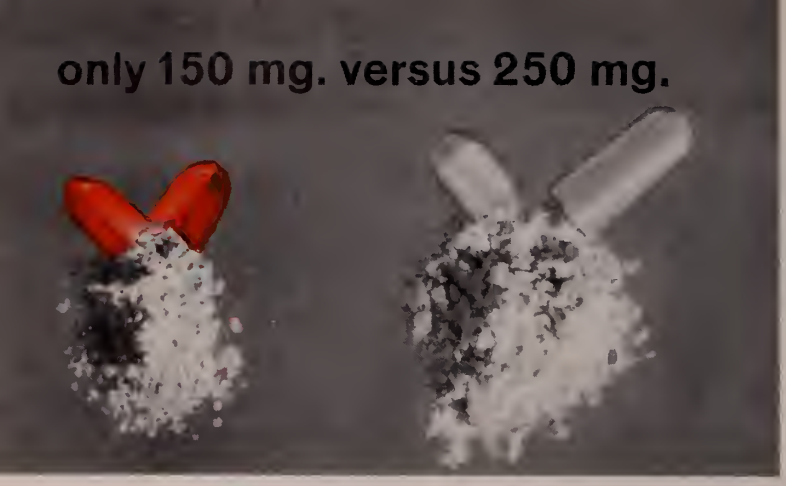
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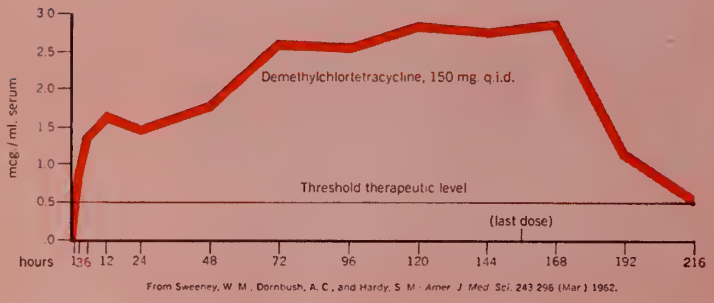
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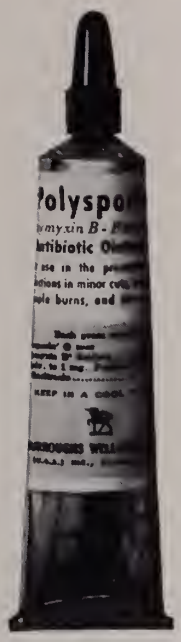
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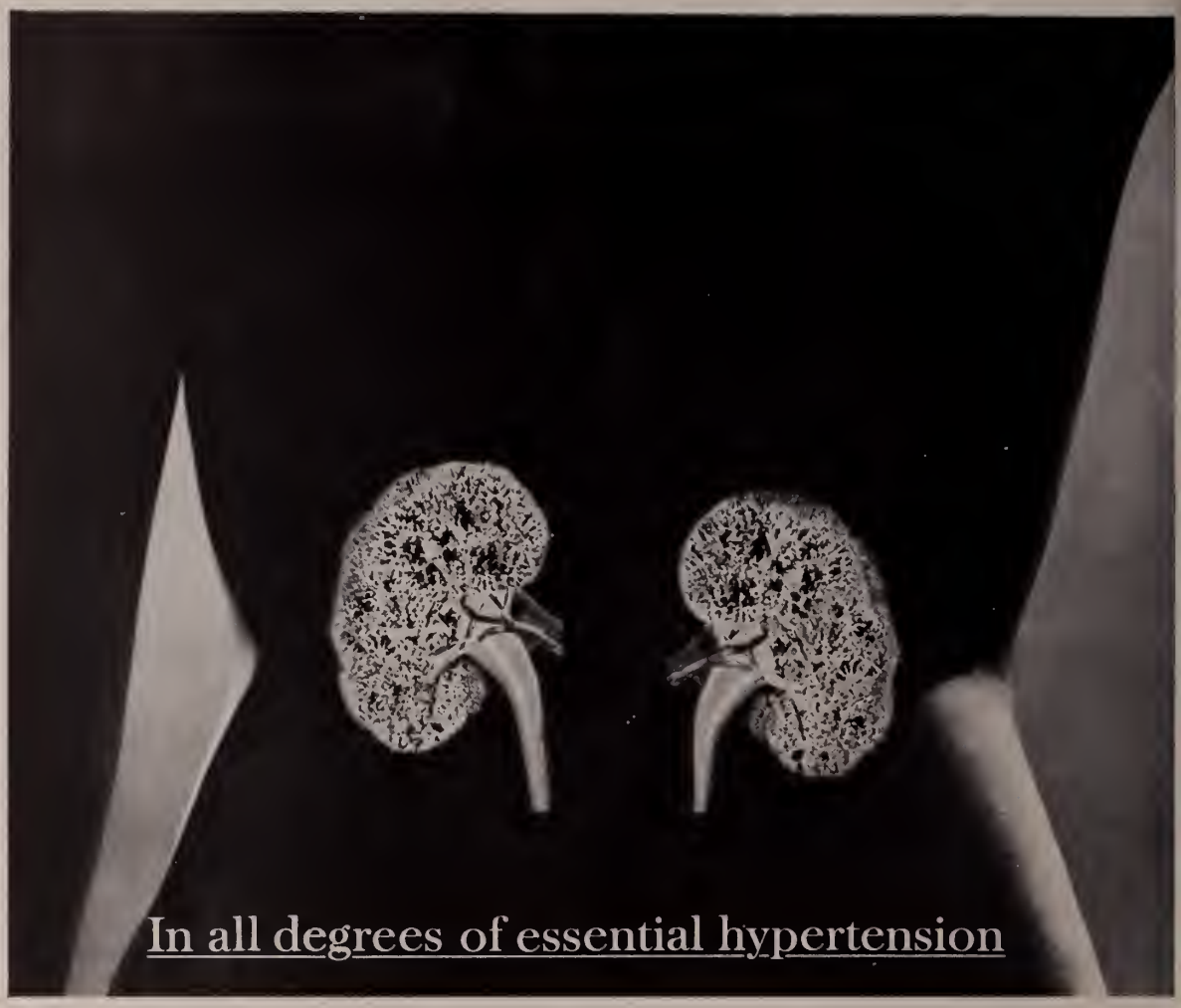
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References: (1) Moyer, J. H., and Heider, C.: Am. J. Cardiol. *9*:920 (June) 1962. (2) Brest, A. N., and Moyer, J. H.: Pennsylvania M. J. *63*:545 (Apr.) 1960. (3) Berry, R. L., and Bray, H. P.: J. Am. Geriatrics Soc. *10*:516 (June) 1962. (4) Hutchison, J. C.: Current Therap. Res. *4*:610 (Dec.) 1962. (5) Feldman, L. H.: North Carolina M. J.: *23*:248 (June) 1962.

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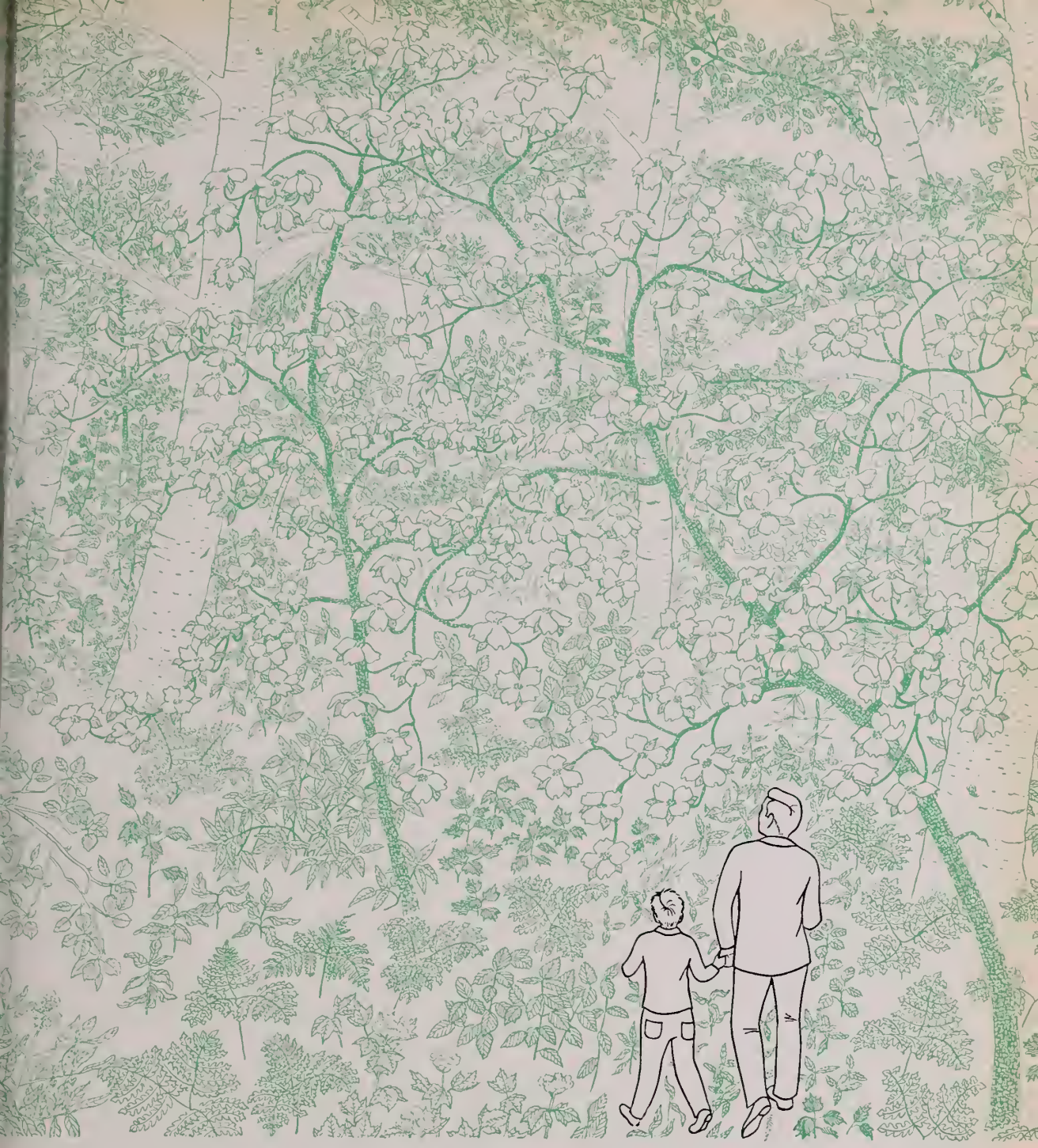
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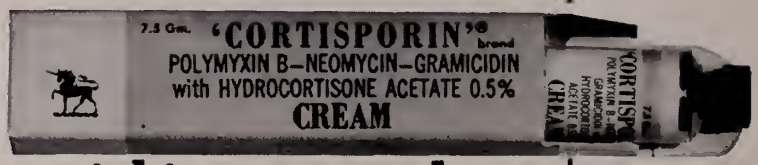
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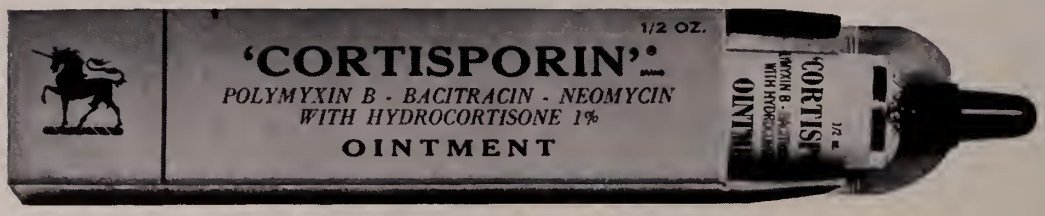
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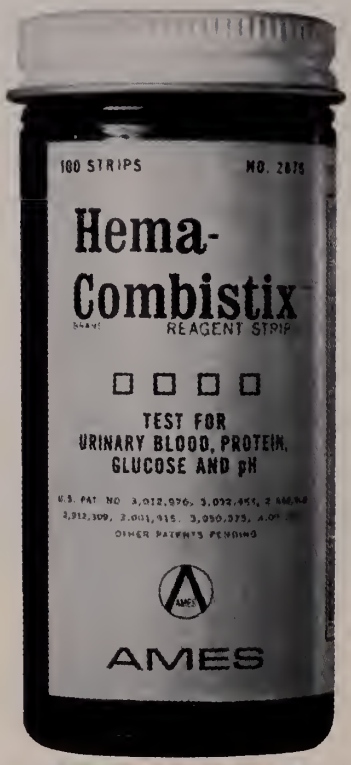
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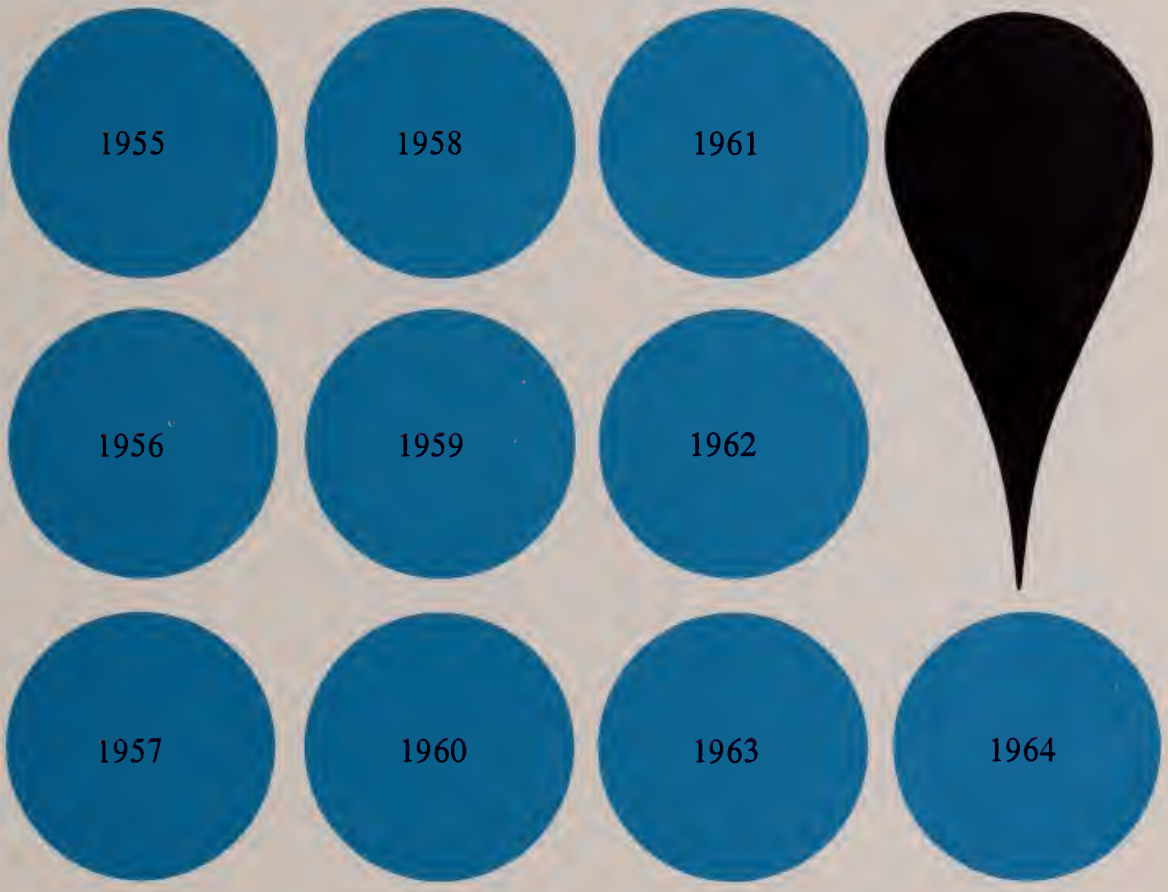


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* AMA Council on Foods and Nutrition: The Regulation of Dietary Fat, *JAMA* 181:411-423 (August 4, 1962).
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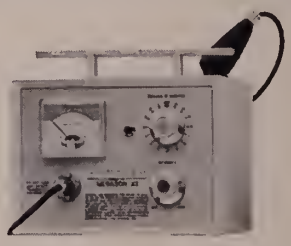
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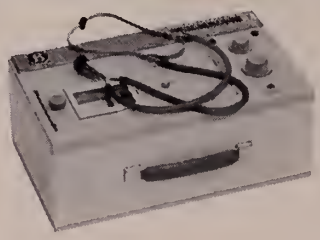
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References: **1.** Szymanski, F. J.: *Indust. Med.* 30:498, Nov., 1961. **2.** Wexler, Louis: *Clin. Med.* 70:404, Feb., 1963. **3.** Hodges, F. T.: *GP* 14:86, Nov., 1956. **4.** McLean, I. E. D.; Graham, K. T., and East, M. O.: *Practitioner* 189:82, July, 1962.

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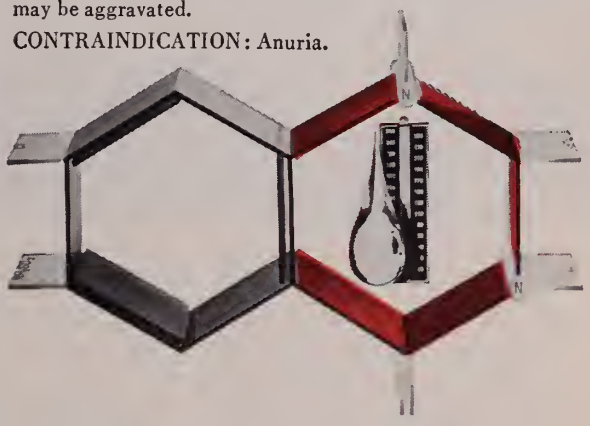
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EDITORIALS

Meet Charles H. Calvin



Not since 1897 (when Dr. David English took office) has our State Society had a President from Middlesex County. And this is strange, for The Medical Society of New Jersey was born in Middlesex County and its first President (Robert McKean), like the current President, came from Perth Amboy. Middlesex physicians, indeed, were prominent in the leadership of The Medical Society of New Jersey during its first half century. (Seven of our first 20 Presidents came from that one county.)

New Jersey medicine's number 1 man now is Charles H. Calvin. Born in 1895, he was graduated from the Perth Amboy High School in 1913. With the outbreak of World War I he promptly enlisted and was with the first Army Air Forces as early as 1917. On being mustered out in 1921, he entered George Washington University, earning his B.S. Degree in 1925. He then was admitted to the medical school of Tufts University, winning his M.D. in 1929. A few months later he came to the Newark City Hospital where he was an intern, later a house physician until 1932. In that year he returned to Perth Amboy and has served the people of that section for the 32 years since that date.

Dr. Calvin has become an organic part of the Raritan Valley medical and civic community. He is a consultant at the Diagnostic Center in Menlo Park and at the Veterans' Home in Edison. He had a tour of duty as president of the governing board of that Home. He has been the School Physician for Edison Township, and served as medical director for the Civil Defense Organization in that area. He is a vestryman of St. Peter's Episcopal Church and has been active in Masonic and Veterans' Organization affairs.

Dr. Calvin has been a key man in medical society activities for many years. He was on our State Society's Nominating Committee, on our State Judicial Council, and has performed numerous committee chores for the State Society with effectiveness and distinction. He has served as president of the Middlesex County Medical Society and of the New Jersey Academy of General Practice. He thus brings to our State Society's top position many years of vigorous medical society and civic leadership at all levels.

Every Doctor Is Two Men

Every doctor is two men. He is a scholar of the psychobiological unit, a learned man—that indeed is what "doctor" means ("he who is taught"). And he is a practitioner, a craftsman of a higher art, the operator of an office—one, indeed, of an organized company of practitioners. In his organizational life, he symbolizes these two activities. Through his county medical society, he unites with fellow-practitioners to fight the good fight on behalf of sound principles of medical care; and thus, in this fellowship he strives to keep himself free to practice medicine as, in good conscience, he feels he must practice it. And in his capacity as an academician, or man of learning, he joins with

his fellow-scholars in scientific and educational bodies like the Academy of Medicine.

To be active only in the Academy is to be but half a physician—for the "practice" side of medicine must be kept strong—and only in the network of organized medicine is there such strength. But to be active only in "official" medical societies is also to be but half a doctor. For the academic side of medicine must also be nourished—and this is the function of the Academies and similar bodies.

In one of his essays (in 1597) Francis Bacon said: "Reading maketh a full man; conference a ready man; and writing maketh an exact man." To be a full man in medicine requires both kinds of organizational devotion. And the academic organization provides, too, the "conference" and the opportunity for writing that together make the doctor a ready man and an exact one.

Shirley Kunderman: New State Auxiliary Leader



Mathematician, champion swimmer, church deaconess, quadruple-threat mother, and a consistent worker for many good civic causes: that, in brief, is Mrs. Philip John Kunderman, incoming president of the Woman's Auxiliary.

As Shirley Buttler, she earned her B.S. in mathematics at Douglass College. She is the wife of Philip J. Kunderman, M.D., director of surgery at Middlesex General Hospital, and chief, or consultant, in thoracic surgery at a half a dozen other hospitals. The new president's curriculum vitae is told, in staccato, this way:

Mother of four children: Gail, 13, 8th grade; Phyllis Jane, 12, 7th grade; Craig Buttler, 10, 5th grade—all in Highland Park public schools; and Stacie Joan, 2½, red-haired delight of the whole family.

Medical auxiliary activities: president of Woman's Auxiliary to the Middlesex County Medical Society for two years, and recording secretary for three years, and introduced the first county health forum; annual reports review book chairman for two years for Woman's Auxiliary to The Medical Society of New Jersey.

First financial secretary of the Middlesex County Homemaker Service; served on the board of the YWCA; on the consistory of First Reformed Church as deaconess; member of her church choir; assisted with two Girl Scout troops, with the Community Health Campaign Fund, with the YWCA Building Fund campaign, the county eye-screening program, and county Sabin Oral Polio Program.

Member of the Woman's Auxiliary to the Middlesex General Hospital, the Woman's Auxiliary to St. Peter's General Hospital, and the Highland Park Woman's Club.

Interested in reading, cooking, music, bridge, and horses.

Athletics: swimming—past New Jersey State Backstroke champion; member of the Watchung Lake Swimming Club; water skiing; bowling; ice and roller skating.

And what does she do in her spare time?

ORIGINAL ARTICLES

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Charles H. Calvin, M.D./Perth Amboy

As I assume the presidency today, I realize that I am the recipient, at your hands, of honor of a magnitude such as I have never known before. I am overwhelmed and humbled by the awareness of your confidence in me and by your gracious kindness. By my conduct in office and the calibre of service which as president I shall render, I am determined to prove that I am worthy of that confidence and appreciative of that kindness.

It is my pledge to you that, as the 172nd president of this distinguished and ancient Society, I shall do all in my power to live up to the splendid example of my illustrious predecessors in office, and to preserve and promote the ideals and standards of life and of service that bind us all together. With your help I have achieved the presidency. With your continuing help and inspiration, I shall acquit myself of all its many obligations for the good of our profession and for the welfare of the people to whom we minister.

It seems to me that members of the profession of Medicine have responsible relationships that bind them almost equally to the past, the present, and the future. We must keep faith with the past, be attuned to the present, and strive to contribute constructively to the fashioning of the future. Only thus can we, in our daily lives and actions, reflect our regard for those who bequeathed to us the inheritance we enjoy, and only thus can we manifest our essential solicitude for those who will receive the inheritance we leave.

From our remote professional ancestors, we inherited a profession of distinction and of dignity. It acquired that character not so much because of the deep scientific knowledge or the expert technical skills of the early practitioners of medicine, but rather because of their personal integrity and worth as men of honor, refinement, and compassionate solicitude for their fellowmen.

The little of help they could bring in the exercise of their crude arts as physicians and surgeons, they gladly and dependably supplied to their patients. The great gift of themselves—compounded of disciplined intelligence, spiritual idealism, sympathetic human interest, and unselfish constancy of devotion—they habitually and generously bestowed.

They showed to their patients, and to all of us who have undertaken to follow in their footsteps, the noble and kindly type of man the doctor of medicine should be. They established in its classic form the doctor-patient relationship, which has been ever since the glory of the profession of medicine and the envy of all other secular professions. Figuratively, they grappled their patients to their souls "with hoops of steel", and honor and love were their unwavering reward.

The relationship of the doctor of old to his patients was as intimate, as personal, and as influential as the relationship of a good father to grateful children. In consequence, the doctor came to hold—by right of merited winning

*Inaugural address, delivered at the annual meeting in Atlantic City, May 19, 1964, by Dr. Calvin on the occasion of his installation as President of The Medical Society of New Jersey.

—a place of authority and exalted esteem not only in the lives but in the minds and hearts of his patients, in sickness and in health until death. This place, this status, they bequeathed to us as a priceless inheritance, an inheritance which we must not lightly permit to become diminished or dissipated, a good name which we must not lose or suffer to be filched from us, or we—and our patients—will be made poor indeed.

From our more proximate professional predecessors—particularly those who have lived and worked since the turn of the century—we have received gifts of scientific knowledge and refined and specialized procedures and technics that have transformed and touched with magic the scope and character of the professional services that we can render.

The practitioners of today—thanks to discoveries and advances in every department of scientific knowledge and their application in the fields of medicine and surgery—are able, as no generation of physicians was ever able before, to vanquish hitherto deadly diseases, soften the effects of the ravages of time, and defer the inevitable triumph of death.

By means of new and efficient power to diagnose, to treat, and to rehabilitate, the doctor of medicine today can not only help his patients to survive attacks of sickness, but he can maintain most of them routinely in vigorous health, so long as they cooperate in the directions given them and do not fall prey to one of the few diseases not yet brought under control.

In the early days of the practice of medicine, the stricken patient only hoped that his doctor could serve even as a limited shield between him and disease and death. Today, matter-of-factly, the average patient confidently expects his doctor not only to stave off for him the attack of disease and the threat of death, but he expects his doctor to restore him promptly to full and unlimited good health.

Good health and vigorous life have become so widespread and familiar in the last half century, in consequence of the conquest of the diseases and maladies that only a short time ago exacted a deadly toll of people of all ages, that they have come to be regarded as a natural right.

People feel that justice is somehow violated if ill health is visited upon them and vigorous life is denied them. They look to their doctors to supply the health and vigor that they seek, even though some of them are constitutionally not equipped to permit it. They not infrequently condemn their doctors as incompetent or neglectful when, despite best efforts, the desired results are not realized. In their disappointment and resentment, some people—and their number is increasing—turn to the courts to redress the alleged violation of their rights and to punish their doctors for having failed in their efforts to make them perfectly well again.

In consequence of all this, today we have a situation in which the profession of medicine is able to serve the health and welfare of people as never before, yet between the people and the members of the profession relations have deteriorated and grown strained. The doctor of distant days, who could give—and who regularly gave—comfort and solace rather than effective treatment, was honored and loved by his contemporaries. But the doctor of today, who can and does work wonders for the physical well-being of his patients, seems in danger of having people take for granted all the good that he does for them while they blame him for not controlling circumstances which frequently are beyond his powers and abilities to control.

To account for the difference in position of the practicing doctor of early times as opposed to the practicing doctor of today, I think we must take into consideration the changes that have taken place in the philosophy and principles of individuals and of society. Predominantly, early Americans—from colonial times up to the time of World War I—were a God-centered people, who, in the Christian tradition, looked upon life as a period of probation in the course of which the individual was to prove himself deserving either of eternal reward or of eternal punishment.

The obligation of the individual, as they saw it, was to so live as to please God and to do good to his fellowmen. Because, in this concept, the individual was accountable to God for his

actions, it followed as a corollary that he must be free to determine the character of those actions. Hence, this concept of individual accountability to God was basic as a motive for individual freedom.

In molding the character of his actions, the free individual took into account the Christian teaching that he had inherited a fallen nature, in consequence of the original sin of Adam and Eve. Perfection on earth and salvation in heaven were dependent upon his not following that nature into impulsive action until he had first submitted the nature and character of the proposed action to conscientious judgment. This attitude of virtuous caution discouraged impetuous self-indulgence and encouraged self-discipline and self-denial when indicated as more consonant with personal virtue or the general good. In consequence, one's rights and desires were seen as proper only when they were compatible with the rights and proper desires of others. Thus liberty for all was yoked to the obligation of insuring justice for all, and the individual who acted in disregard of this exaction did so at peril of both his temporal and eternal acceptability and well-being.

Success in life for a man so oriented was measured in his being able to meet the challenges of life with satisfaction to himself, to his fellowmen, and to God. The satisfaction of these spiritual criteria did not preclude the pursuit of temporal satisfactions, but it never permitted the attainment of temporal satisfactions at the sacrifice of spiritual standards.

In the last fifty years great changes have occurred in the philosophy and principles of both individuals and society. Material and temporal goals and satisfactions have assumed increasing importance for individuals and for society. For many the state has replaced God as the sovereign power, and the service and satisfaction of self have progressively become their paramount, if not their only, goal. The nature of man has been exonerated of all defect, and he has been encouraged in his development and growth, without reference to conscience or the rights or comfort of others, to persevere in "doing what comes naturally." Whatever such a one wants he regards as a natural need, and whatever he thus naturally needs he assumes he is entitled to have.

Indulgence of this philosophy has led us, as a people, individually and collectively, in many instances to demand that which we have not earned and to which we have no defensible title in justice. It leads, day by day, to the rejection by the individual of all authority except his own. When conflict develops with civil authority and civil law, he refuses to defer to either. The upshot of all this is mirrored in the life of our times. It constitutes a chronicle of disrespect, disorder, discord, violence, and widespread dissatisfaction. Apparently everyone is busy trying to do what he wants to do, with no regard or respect for authorities or rights other than his own, and with no sense of accountability to higher law other than the law of callous self-interest. Yet apparently very few people are really satisfied or happy, and by and large society at all levels is unstable and insecure. Resentments flourish and life constantly surges in fretful flux.

It is difficult, though not by any means impossible, to resist the contagion of selfish materialism which everywhere abounds. But resist it we must. Its presence is a threat to the continued existence of a society which seeks and exalts freedom, justice, responsibility, and dignity, and recognizes and respects genuine and properly constituted authority. The flowers of the future inevitably spring from seeds sown in the present. We who live in the present hold the future in our hands, but we must mold it in our hearts.

As men and women of medicine, health is our proper concern . . . not just the physical health of individuals but their *total health*, as embracing physical, mental, and spiritual components. Healthy, well-balanced individuals make for a healthy, well-balanced society. Thus we can and should contribute to, and be solicitous regarding, not only the total health of individual men and women but the total health of the society which they collectively constitute. There is no greater or more important task than that which is ours, to build better men and women everywhere and through them to build a better, healthier, happier world.

Let us keep faith with the past by being true to the pattern of personal worth and greatness which our remote professional ancestors laid down for us. Let us be attuned to the present by keeping abreast of all scientific progress in order that we may better serve the needs of the people whom we tend. Let us insure the worth and character of the future by giving of our best, and by inspiring and encouraging all with whom we come in contact to cooperate by giving theirs. In this way we will preserve and add to the status of medicine, we will strengthen its authority, we will enlarge and improve its place in the general esteem, and we will fulfill our proclaimed destiny to be health-bringers and help-bringers to a world in genuine need.

80 Commerce Street

The Doctor's Third Arm

The Rehabilitation Program

The New Jersey Rehabilitation Commission (a Federal-State agency) provides vocational rehabilitation services to physically or mentally disabled persons of working age who are residents of the State. The disability must constitute a job handicap where vocational rehabilitation services can reasonably be expected to return the disabled individual to a job. People with acute illnesses or disabilities are not eligible until stabilized.

Vocational rehabilitation services may include any of the following: medical, psychiatric, surgical or psychological examination and treatment; hospitalization, prosthetic, and related services; vocational training, counseling, and job placement. Substantial results should be likely within a reasonable period of time in order for the individual to be eligible for services.

Over-all medical guidance is retained by the treating physician, and therapy measures are considered by the Rehabilitation Commission upon the physician's recommendation. In any case, the Rehabilitation Commission must finally pass on any recommendations.

What about cost? Medical examinations, guidance counseling, training, and placement can be given to eligible clients without cost. Expenses for medical services, living allowances, carfare, books, supplies, tools, and equipment are arranged for by the Commission, based on the client's ability to pay.

For quickest service or information, call the office in your area. Jot the number down for easy reference.

A short talk to any group outlining the functions of the New Jersey Rehabilitation Commission can be arranged upon request.

Which office is nearest you?

Asbury Park	— 710 Mattison Ave., PRospect 4-1575
Atlantic City	— New York and Atlantic Aves., 345-5965
Bridgeton	— 22 Washington Street, GLenview 1-9098
Camden	— 413 Broadway, WOodlawn 6-2893
Elizabeth	— 520 Westfield Ave., 351-5434
Hackensack	— 10 Banta Place, DIamond 2-0803
Jersey City	— 895 Bergen Ave., OLdfield 3-2350
Morristown	— 5 Schuyler Place, JEfferson 9-3660
Newark	— 309 Washington St. (4th fl.), MArket 3-4235
New Brunswick	— 96 Bayard St., KIlmer 5-8120
Paterson	— 370 Broadway, ARmory 1-3050
Trenton	— Labor & Industry Bldg. (Room 1111), 292-2940

ADMINISTRATIVE OFFICE — Labor and Industry Building, John Fitch Plaza, Trenton Room 1209 — Phone: 292-2351

(See the May 1964 issue of this JOURNAL for more details about the program)

The pregnant cardiac patient needs team treatment: the anesthesiologist, the obstetrician, and the cardiologist. In this brief monograph, three such specialists suggest how this cooperation may be affected.

Heart Disease in Pregnancy*

A Three-Dimensional View

E. J. Slowinski, M.D./West Orange
Gene D'Alessandro, M.D./Glen Ridge
Joseph Stein, M.D./Camden

The work presented below is a compilation of the thoughts and experiences of an obstetrician (Dr. Slowinski), an anesthesiologist (Dr. D'Alessandro) and a cardiologist (Dr. Stein).

The Role of The Obstetrician

In the management of the pregnant cardiac patient, the obstetrician has three jobs: (a) Preventive medicine, (b) Prenatal care, and (c) Management at the delivery and puerperium.

Preventive Medicine. As a health educator, the obstetrician stands in a unique position between the pediatrician and the geriatrician. He is often the only physician to see the young adult female and has responsibility in general health matters. For example, proper nutritional standards are often sinned against by these young women in their "teen" years and during their careers as young homemakers. By preaching the basic elements of good nutrition, the obstetrician may help prevent the relative iron deficiency anemias and hypo-vitaminoses which set them up for other diseases.

Many disease processes in pregnancy require the assistance of an internist in diagnosis and management. In cardiac diseases, we, as obstetricians, should establish a set of signs and symptoms which, when discovered in early pregnancy, would be sufficient to have us refer the patient to an internist for a complete evaluation.

FIGURE 1

CARDINAL SIGNS AND SYMPTOMS REQUIRING CARDIAC CONSULTATION

History of Rheumatic Fever
Diastolic or Significant Systolic Murmur
Orthopnea or Paroxysmal Nocturnal Dyspnea
Hypertension in Early Pregnancy
Unexplained Tachycardia
Other Arrhythmias

Figure I shows six cardinal signs and symptoms which I use. To this list each physician could add his own favorite "tip-off" symptom complex. It is important, however, that each physician keep in his mind those criteria for which he will subject the patient to an extensive cardiac evaluation, and *stick to them.*

Prenatal Care: There are roles for both the obstetrician and the internist in the prenatal management of the woman with heart disease. These physicians must work *together* and not *alternately* in such management. The patient is not at one time a walking uterus and at another time a walking heart; but too often this is the way she is viewed. During the prenatal course, therefore, whenever one of the team sees the patient, he must promptly call the other, or at least immediately send a memorandum of his findings and, most important, any particulars concerning newly added medication.

*Read at the Annual Meeting of The Medical Society of New Jersey, May 13, 1963.

The management of the pregnant cardiac patient is not the place for corridor consultations or restroom reports. The selection of the medical consultant will often be based upon his past history of *cooperation with, and interest in, the obstetrician, as well as the patient.*

In prenatal care of the cardiac, the most important aspect is the prevention of congestive heart failure. The obstetrician and the cardiologist share responsibility for early detection and prompt treatment. Both must guard the diminished cardiac reserve; and any sign suggestive of upper respiratory infections must be suspect as impending congestive heart failure and treated as such.

The late Dr. Harold Gorenberg of Jersey City was responsible for a logical and practical system of prenatal management of pregnant cardiacs. This was published in the JOURNAL of The New Jersey Medical Society in 1956 and, with apologies to his co-workers on various papers on this subject, Dr. Leon Chesley and Dr. John McGeary, I would like to refer to the following tenets of good prenatal care as GORENBERG'S PRINCIPLES. These are presented in Figure II.

FIGURE II

GOREMBERG'S PRINCIPLES

RULE I:	Extra bed rest.
RULE II:	Weekly clinic visits for the cardiac who is age 25 or older.
RULE III:	Immediate hospitalization for Class III and IV cardiacs and absolute bedrest until after delivery.
RULE IV:	Immediate hospitalization for the patient with a history of cardiac failure, with absolute bed rest until after delivery.
RULE V:	Immediate hospitalization at the first suspicion of decreasing cardiac reserve.
RULE VI:	Cesarean section for obstetric indications only.

In Figure III is given the examples of work, measured in calories per minute, the pregnant patient does around the house in an ordinary

FIGURE III

ENERGY COSTS OF VARIOUS HOUSEHOLD ACTIVITIES
MEASURED IN CALORIES PER MINUTE.



(Reproduced by permission of the author from an exhibit "Regulation of Physical Activity in Management of Chronic Disease. Energy Costs of Various Activities in Work and Play" — A.M.A. Scientific Exhibits, 1957, published by Grune and Stratton, New York)

day. If these high energy output activities are restricted, the burden upon the heart imposed by pregnancy can be tolerated as other burdens are removed. This becomes more significant in the thirty-third to thirty-sixth week of pregnancy when the burden is known to be at its greatest.

Management at labor and delivery: There is no magic method of anesthesia for these deliveries. More important than the selection of a specific technic is the correct and experienced use of any method which is comfortable and familiar to the obstetrician and his staff as long as it maintains proper oxygenation.

One of the cardinal principles in the selection of anesthesia is to protect the decreased cardiac reserve. Any strain put upon it by sudden hypotension, tachycardia, other arrhythmias, and episodes of vomiting is dangerous. The much publicized conduction anesthetic saddle blocks, caudal blocks, and presacrals can be used very successfully in these cases. However, hypotensive episodes with associated tachycardias are much more frequent with these technics. Only one experienced with them, one who knows how to combat sudden hypotension, should give these anesthesias.

The selection of method of vaginal delivery will also depend upon procedures familiar and comfortable to the obstetrician and hospital staff. Much has been said about the judicious shortening of the second stage of labor in the pregnant cardiac to diminish the work load put upon her. Most cardiacs do extremely well in labor, and the additional few minutes will be much less of a burden that the injudicious use of forceps too early with episiotomy extention, postpartum hemorrhage, and tachycardia leading to congestive failure. These complications are not uncommon in mid-forceps deliveries. This is not to condemn the correctly used outlet forceps, which will eliminate the pushing efforts of the pregnant cardiac patient at these last few minutes.

The combination of heart disease and pregnancy is *not* an indication for a cesarean section. However, if one *is* indicated in a pregnant cardiac patient (for purely obstetrical reasons) it should be done promptly when all necessary facilities have been made available. Again, in the selection of anesthesia, the customs and usages of the hospital must be taken into consideration.

"Bloodless phlebotomy," or the rotation of tourniquet on the extremeties, is often used in the management of acute congestive failure to reduce the circulating blood volume. This depends upon the pooling of blood into the extremities. This same pooling of the blood must be considered when the cardiac patient is positioned for delivery. The sudden elevation into stirrups of both legs can dump into the circulating blood volume as much as two pints of blood jeopardizing the diminished cardiac reserve and causing congestive failure. In the serious of Class III or IV cardiac patient, the Walcher position (Figure IV) is superior to the standard Lithotomy position for delivery

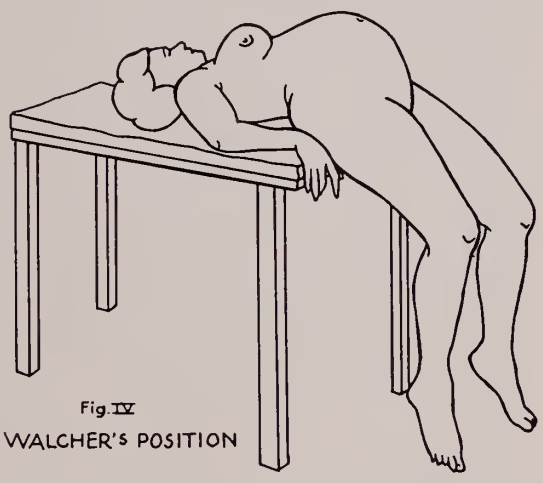


Fig. IV
WALCHER'S POSITION

and simulates "bloodless phlebotomy." In this position, the legs are not lifted beyond the horizontal and are held widely adducted by two assistants giving ample room for the manipulation of the perineum, episiotomy, and repair. This position is better adaptable in the United States than is the Sims or lateral position, which has never gained much enthusiasm in this country.

Intravenous injections of ergot derivatives has a tendency to raise venous pressure and may at time cause great changes in the blood pressure. It is, therefore, omitted in the immediate postpartum situation. Preferable to it is pitocin administered intramuscularly or intravenously

by drip in a small volume of five percent glucose in distilled water.

After delivery, in severe cases, Fowler's position with continued oxygen administration is suggested for the first twenty-four hours postpartum. Abdominal binders and sand-bags are not applied because of their obstruction to easy respiration and also their predisposition to thrombophlebitis. Nursing is discouraged because of the increased fluid and metabolic demands as well as the increased incidence of mastitis in the nursing mother.

Care of the puerperium: Although often disregarded in this country, the "fourth trimester of pregnancy" is considered very important in Europe. One series from Vienna indicated that 88 per cent of the deaths referable to cardiac disease in pregnancy actually took place during the first three months postpartum. It is ironic that the caution and care which is enforced throughout the pregnancy, labor, and delivery is often thrown to the winds when the patient is discharged from the hospital a week or ten days after delivery.

Adequate follow-up of these patients is difficult but urgent. The rest habits and the diminished burdens of work load which were taught during pregnancy must be continued during the puerperal period until the patient has resumed normal menstrual flow and can be considered out of the obstetrician's authority.

The Anesthesiologist

The leading cause of maternal deaths in recent years has been heart disease. While the incidence of deaths in sepsis, toxemia, and hemorrhage has decreased dramatically where good prenatal care is available, the death rate for the pregnant cardiac patient has not. The maternal mortality before 1925 was ten percent in cardiac patients. This is still the mortality rate in the neglected pregnant woman; however, when adequate treatment is instituted, this rate can be decreased to between one and two percent.

The patients most likely to present a problem to the anesthesiologist are those with the more severe type of heart disease with incipient or actual decompensation. Cardiac output increases during pregnancy early before an apparent metabolic need for it. When it seems that the need is greatest in the last weeks of pregnancy, it falls toward the non-pregnant level. In early pregnancy the tissues do not extract the usual proportion of oxygen from the blood. In late pregnancy the oxygen extraction increases and this compensates for the falling cardiac output.

Pregnant women in functional Class I and II have essentially normal hemodynamics. The only difference between pregnant and non-pregnant patients with mitral valvular disease seems to be the slightly higher cardiac output and lower pulmonary vascular pressures in the pregnant patient.

In Class III and IV the situation is somewhat different. In non-pregnant patients, the cardiac output rises to normal thus upsetting the balance between cardiac output and the vascular pressure in the lungs. This makes the pregnant woman with a tight mitral stenosis especially susceptible to pulmonary edema. It also explains in some measure the marked improvement resulting from the relaxation of the peripheral vascular resistence produced by major conduction anesthesia.

Analgesic technic for labor progressing in the presence of symptomatic heart disease must be directed toward insuring continuously adequate oxygenation, good relief of pain and emotional distress, and avoidance of straining. During the early stages medication should include moderate sedation to minimize the physical and emotional burden.

The question of regional versus general analgesia for the second half of labor and of delivery is somewhat controversial. It may seem unwarranted to cause slowing of labor and the necessity of forceps delivery by instituting an epidural block. Yet the relief of pain and the elimination of straining protects a badly over-burdened heart. The bloodless phlebotomy producted by the epidural injection can relieve the heart of the burden of a high venous return. Caudal or paravertebral epidural blocks are therefore the preferred anesthesia. The danger of frank decompensation is proportional to the additional strain placed upon the heart by the rigor

of labor and delivery. In the cardiac patient, the Valsalva effect of bearing down may produce a marked reduction in the cardiac output and acute collapse. Epidural anesthesia minimized this. With the patient at ease, the contractions bring the presenting part to the point where outlet forceps and episiotomy will deliver the baby without adding undue stress to the already taxed cardiovascular system.

Postpartum Care: Cardiac distress often increased dramatically immediately after delivery. Venous pressure is increased by the great reduction in uterine blood-flow, the release of the pressure exerted by the gravid uterus on the inferior vena cava, and the increased amplitude of respiration. Vasodilatation following epidural block would tend to permit a more gradual accommodation to the effects of the emptying of the uterus.

Alternatives: If epidural block is contraindicated, a saddle block is suitable. As a third choice, local anesthesia for delivery is advisable providing there is adequate and satisfactory control of emotional stress.

In patients to whom being completely awake with regional anesthesia presents an unsurmountable psychological strain, delivery may be eased with the help of moderate sedation and terminal light general anesthesia. The agent of choice is halothane†.

In many hospitals, anesthesia coverage for the obstetrical patient is far from ideal. In such situations it is better to use local anesthesia, sedation, and nitrous oxide-oxygen analgesia than to subject the patient to the struggling and breath-holding that ensues from an incompetent administration of anesthesia.

The Cardiologist

During pregnancy, physiologic stress increases to about the seventh month and then decreases, If a pregnant cardiac patient successfully weathers the seventh month, she is unlikely to encounter difficulties.

It is wise to secure the proper cooperation from the patient and the family during these critical months by a careful evaluation of the problems with them. The doctor should be as reassuring as possible consistent with the situation. Emotional upsets should be kept at a minimum and an explanation of the situation to the family generally will reduce this possibility.

Rheumatic heart disease accounts for 90 per cent of the cardiovascular lesions in the pregnant woman and of these, about three-fourths consist of mitral stenosis alone or in combination with other lesions. At first evaluation, the pregnant cardiac usually can be recognized as a good or a poor risk. Perhaps the single most important point of differentiation is the assessment of her exercise tolerance. A crude test would be the equivalent of running up two flights of steps. If this can be done without dyspnea, she probably will experience no difficulty in child bearing. The best risk patient has no symptoms.

Other factors (besides functional class and type of valvular lesions) must be considered in the initial evaluation. The age, the size of the heart, the disturbance of the rhythm, and concomitant diseases are all significant. All things being equal, an older patient should have more difficulty. An obviously enlarged heart has less reserve than a normal or slightly enlarged one. Atrial fibrilation generally adds to the likelihood of failure.

Toxemia: The relationship of toxemia to the heart disease is not clearly defined, but there is evidence to suggest that heart disease predisposes to the development of toxemia. When we realize this possibility and the seriousness of the added burden, careful observance for the earliest sign of toxemia should be made and treatment vigorously instituted as soon as this diagnosis is suspected.

Congestive Failure: The primary goal in the management of the pregnant cardiac is the prevention of congestive failure. It is, therefore, wiser to consider that there is only *one* disaster that can befall her: congestive heart failure. Even minor conditions should be handled as if they were equivalents of heart failure. For example, a mild respiratory infection should be treated with strict rest.

On occasion, it may be difficult to make a differential diagnosis between early congestive

†Available under the Ayerst trade-name of Fluothane®.

failure and the physiologic state. In these circumstances, two tests may prove helpful. The first is the vital capacity which may signal early pulmonary congestion even before subjective dyspnea develops. When dyspnea is present, if it is due to the hyperventilation of normal pregnancy, there should be no decrease in vital capacity. In pulmonary congestion, however, it should be attended by a very definite reduction in vital capacity.

In the presence of congestive failure, the use of a potent diuretic should produce an improvement in the symptoms together with a loss of several pounds of body weight. If there is any doubt, a circulation time may be helpful to establish the diagnosis of congestive failure.

If congestive failure does develop, treatment should be no different than for any other type of cardiac patient in failure. Digitalization should be initiated, and it is much better to err on the side of premature use than not to use that drug when failure is incipient. If the heart rate at successive visits increases, it may be wise to initiate the use of digitalis before waiting for other signs.

Prenatal Considerations: Dietary calcium increases the sensitivity of the patient to digitalis. Intoxication can then occur with doses far below the usual therapeutic level. Therefore, discontinue calcium therapy when digitalis is used.

The role of infection must be stressed. If the patient is not on prophylactic penicillin, she should be put on an adequate dosage. Prompt attention must be paid to any infection when the patient develops dyspnea, unusual fatigue, swelling of the feet, excess gain in weight, or arrhythmias.

Hemoptysis must be reported immediately. Less obvious danger signals include those of unusual fatigue, insomnia, and paroxysmal dyspnea. A heart rate of more than 90 per minute in a patient with significant mitral stenosis should be treated with considerable respect; over 100 it should be considered as a danger signal. If it reaches 110 it must be regarded as an emergency. The surgical interference in the form of a therapeutic abortion or cesarean section is rarely, if ever, indicated on a cardiologic basis. However, mitral valvulotomy may be a necessary procedure during pregnancy and should be done as early as possible. As a general rule, however, such surgery should be postponed until after delivery. A definite mortality rate is associated with the operation and, in pregnancy, there is a double hazard to mother and infant which makes the operation almost prohibitive except in poor functional class patients.

Labor and Delivery: Labor seems to be better tolerated than the sustained hemodynamic burdens of the sixth and seventh months because it represents an intermittent rather than a continued muscular exertion. At delivery, a new situation is present. The patient should be properly sedated, and the pulse and respiratory rate repeatedly checked. A pulse rise to 110 per minute should be considered as impending heart failure. Atropine and scopolamine should be avoided. It is safer to keep the patient out of bed and in the chair for as much as possible during the first stage. If the patient is in bed, the head of the bed should be elevated as high as practicable. This does not compensate for the advantages of keeping the legs dependent. On the delivery table the patient's head should be kept unconventionally high, and the Trendelenburg position obviously should be avoided.

Puerperium: Immediately after delivery, the vital capacity falls abruptly and the venous return and cardiac output rises. This, therefore, constitutes another danger zone. It is important to minimize the readjustments occurring at this time. Venous tourniquets should be applied to the legs, and the head should be kept high. The already increased venous return should not be augmented by giving oxytocics if this can be avoided. Parental fluids should be avoided, if possible, and no sodium should be included in them. Moderate blood loss, if it can be controlled, should not be corrected by transfusions. Penicillin and/or streptomycin should be given during the third stage and continued for three days postpartum to prevent a bacterial endocarditis. During the first two weeks after delivery, the patient should be on a salt restriction diet and rest. Digitalis and diuretics should not be withdrawn for at least ten days, and the patient should be kept in the hospital for a longer than usual period to assure continued and proper treatment.

248 Northfield Ave. (Dr. Slowinski)

Like the age-old battle between weapons and armor, the wide use of antibiotics seems to be provoking better defenses in the bacteria.

Adjuvant to Antibiotic Therapy in Staphylococcal Infections

A Preliminary Investigation

W. W. McEwen
Frimley, Hampshire, England

By an apparent paradox, antibiotic treatment of both acute and chronic staphylococcal infections appears to be bringing in its train a correspondingly greater incidence of both conditions. The staphylococcus is now considered a major hazard in medical and surgical wards. It also seems to be responsible for increasing numbers of secondary respiratory and gastrointestinal infections following antibiotic therapy.

The staphylococcus is carried as a commensal organism by a high proportion of the population; yet disease as a direct result of its presence was, at one time, less common than at present. Prior to the introduction of antibiotics, the presence of staphylococci in carriers, hospital wards, and in closed and open lesions was at least as common—possibly more so—than at present.

Why then this recent increase of serious conditions resulting from the staphylococcus? It is postulated that, before the introduction of antibiotic therapy (much of it promiscuous and incomplete), the natural "antigen versus antibody" mechanism accounted for its eventual elimination or suppression in most instances.

A good military tactician does not launch a major offensive without first securing his defenses against a counter attack. The rapid suppression of an initial invasion of potentially virulent organisms with antibiotics before the natural defensive mechanism of the body is provoked leaves the subject susceptible to further invasion when treatment stops. Also, surviving bacteria undergo metabolic changes (such as the development of an ability to produce specific enzymes,* penicillinase for example) by prolonged association with body-tissues impregnated with sub-lethal quantities of antibiotics.

In a recent investigation involving the titration of agglutinins in the patients' blood serum to various test-organisms, two "normal" controls inadvertently developed minor staphylococcal infections during the trial. Neither was treated with antibiotics. Their agglutination titre to staphylococcus aureus had risen considerably by the end of the trial period.

The first developed boils, and his agglutination titre to staphylococcus aureus rose from 1 to 80 at commencement to 1 to 160 at the end of the trial.

The second developed a septic finger midway through the trial period and from which Staphylococcus aureus was cultured. His agglutination titre to Staphylococcus aureus rose from 1 to 10 prior to the infection to 1 to 80 at the end of the trial.

Object of the Project

To determine whether oral administration of a lysate of Staphylococcus aureus to laboratory

*This is the British name for the product which Britain markets under the trade name of Merthiolate.

animals would provoke (or enhance) the production of antibodies sufficient to afford protection against a challenge with viable organisms.

Materials

1. A vaccine consisting of a lysate of Staphylococcus aureus (phage-type 80) equivalent to 1,000 million organisms per cubic centimeters containing a non-ionic detergent and preserved with *Thiomersal. Electrophoretic separation of this lysate showed movement of the soluble protein fractions with movement of almost the entire polysaccharide complex and lipoid fractions.
2. A formol-saline suspension of an 18 hour culture of Staphylococcus aureus (phage-type 80) grown on chocolate-blood agar.
3. Staphylococcal antigen prepared in a similar manner to the gonococcal antigen devised by Price (L.C.C. Monograph No. 2995, 1933).
4. Sheeps' red cells and Amboceptor (Burroughs Wellcome)
5. Complement: fresh guinea-pig serum.
6. Young Albino guinea-pigs and mice.
7. A challenging culture consisting of an 18 hour culture of Staphylococcus aureus (phage-type 80); grown on chocolate-blood agar after two passages through mice, mixed with 5 per cent Hog gastric mucin just prior to use.

Methods

For the purpose of this investigation the work was divided into three phases:

1. Precipitin and agglutination reactions using the serum of treated and untreated guinea-pigs and one human subject against the prepared antigen and a suspension of staphylococcus aureus.
2. Complement fixation tests.
3. Challenge of treated and untreated animals with a viable culture of Staphylococcus aureus. For this phase both passively and actively immunised mice were used.

Three groups of guinea-pigs were used. Group 1 received intra-nasal instillation of 2 milliliters of vaccine at the rate of 0.01 milliliters per day. Group 2 received 4.5 milliliters of vaccine orally at the rate of 0.25 milliliters per day. Group 3 were given no vaccine but kept under identical conditions and were used as controls.

At the end of the treatment period the guinea-pigs were sacrificed, the blood collected, and the serum of each group pooled. Each pooled serum was then divided, part being used for the passive immunisation of mice, part for precipitin and agglutination reactions, and part (inactivated at 56°C for 1 hour) for complement fixation tests. Mice were injected intraperitoneally with guinea-pig immune serum and then with a challenge dose of staphylococci suspended in hog gastric mucin. A further series of mice were given 1 milliliter of the vaccine orally in daily doses of 0.05 milliliters and these in parallel with control mice were similarly challenged. In all instances, the animals unwittingly co-operated with the oral administration by refusing to swallow and they invariably held the vaccine in their mouths until released.

Results:

Precipitin reactions

Capillary-tube technic (ring test) using the prepared antigen and the vaccine.

	Antigen	Vaccine
Group 1	++	+
Group 2	++	+
Group 3	+	++

Agglutination reaction

Group 1 — Serum agglutinated staphylococcus to a dilution of 1:320

Group 2 — Serum agglutinated staphylococcus to a dilution of 1:640

Group 3 — Serum (control) agglutinated staphylococcus to a dilution of 1:40

With the widespread incidence of staphylococci some degree of antibody throughout the animal kingdom could be anticipated. This is confirmed in the case of normal guinea-pigs by the above results and by the comple-

TABLE I

Tube Number	1	2	3	4	5	6	7	8	9	10	11
M. H. D.'s of Complement in 1 vol. N/Saline	2	2.1	2.2	2.3	2.4	2.5	2.6	2.7	2.8	2.9	3.0
Antigen Dilution 2.5 M. H. D. Complement at titration	1 vol. to each tube										
Test Serum diluted 1 – 5	1 vol. to each tube										
Incubated at 37°C for 1 hour in water-bath											
Haemolytic System 3% sheep-cells sensitized with 5 M. H. D. of Amboceptor	1 vol. to each tube										
Incubated at 37°C for 1/2–hour in water-bath and results recorded immediately afterwards											
RESULTS											
Group 1 Serum (Nasal Treatment)	6	6	6	6	5	4	3	3	3	2	0
Group 2 (Oral Treatment)	6	6	6	6	5	5	4	2	2	0	0
Group 3 (No Treatment)	6	6	6	4	4	4	2	2	1	0	0
Reagent Controls				6	6	1	0	0	0	0	0

Interpretation: Degrees of Complement-Fixation expressed numerically from 6 (complete fixation) to 0 (Complete Haemolysis)

ment fixation tests reported later. Jensen demonstrated staphylococcal antibody in "normal" human serum and Fisher has titrated the Staph antibody present in "normal" human adults by a "mouse-protection" technique.

Complement Fixation Tests

Using Staphylococcus (phage-type 80) antigen, guinea-pig complement and sheeps erythrocytes.

Following series of preliminary tests over varying ranges of dilutions of test sera and reagents, the following test procedure was adopted:

To allow for slight variations in the reagents on standing, a further control series of tubes was included with the test proper and which, as will be seen from the table, showed that the complement fixation factor of the antigen was 2.4 M.H.D. at the time of the actual test.

Passive Immunisation

TABLE II

FIRST SERIES	Group 1 12 mice receiving 0.5 ml of group 1 g/pig serum	Group 2 12 mice receiving 0.5 ml of group 2 g/pig serum	Group 3 12 mice receiving 0.5 ml of group 3 g/pig serum
	All challenged at the time serum was given with approx. 100,000 staphylococci suspended in 0.4 ml of 5% Hog gastric mucin		
Hours			
24		1 OR	1 OR
48			
DEATHS 72		1	
96			
120			
144			
Percentage Survival	100%	83.3%	91.6%
SECOND SERIES	0.25 ml of group 1 g/pig serum	0.25 ml of group 2 g/pig serum	0.25 ml of group 3 g/pig serum
	All challenged as above		
Hours			
24			1 OR
48		1 OR	1 OR
DEATHS 72			
96			
120			
144			
Percentage Survival	100%	91.6%	83.3%
THIRD SERIES	0.1 ml of group 1 g/pig serum	0.1 ml of group 2 g/pig serum	0.1 ml of group 3 g/pig serum
	All challenged as above but 30 minutes after administration of sera		
Hours			
24		1(OR/P&HB)	2(OR/P&H/B)
48	2(OR/P&H/B)	1(OR/P&HB)	2(OR/P&H/B)
DEATHS 72			
96			1(OR localised abcess)
120			1
144			1(OR localised abcess)
Percentage Survival	83.3%	83.3%	41.6%

Two mice in group 1 and three in group 2 developed local abcesses at the site of inoculation but these remained localised and the mice appeared otherwise healthy and continued to feed normally.

An interesting feature throughout all the tests has been the evidence of delayed lysis of the haemolytic system occurring between one and two hours after completion of the incubation period. This lysis, once it commenced, became progressively rapid until, at the end of three hours, almost complete lysis had occurred in all tubes containing the antigen and serum. These findings point to the probable presence of lytic factors in the antigen and conform to similar findings by a number of observers (Topley and Wilson 1957).

The variation of degrees of lysis between groups 1, 2 and 3 and the control tubes could be due to the heat-stable anti-lysins in the test sera. This is further indicated by the variation between the treated groups and the untreated group. In the reagent controls which contained no serum other than Amboceptor (in the haemolytic system) the distinction between complete fixation and complete haemolysis at the end of the test period is sharply defined.

Nevertheless, the results recorded immediately at the termination of the final incubation period (i.e. thirty minutes after addition of the haemolytic system) were clear-cut enough to indicate an appreciable degree of complement fixation by the test sera.

In view of the precipitin and agglutination re-

TABLE III

	12 mice receiving 1 ml of vaccine orally in daily doses of 0.05 ml	12 control mice receiving no vaccine
	All challenged with approximately 100,000 staphylococci in 0.4 ml of 5% Hog gastric mucin	
Hours		
24	2(OR/P&HB)	2(OR/P&H/B)
48		6(5OR/P&H/B)
DEATHS 72		1
96		
120		
144		
Percentage Survival	83.3%	25%

Key to tables: O. R. Organisms recovered at autopsy
P. Peritoneal cavity
H/B Heart-blood

sults obtained with the control serum (group 3) indicating a degree of natural immunity to staphylococci, some complement fixation could also be anticipated here.

Active Immunisation

12 young albino mice received 1 milliliter of vaccine in daily doses of 0.05 milliliter and were then challenged, seven days after the last dose of vaccine, with 100,000 Staph aureus in 0.4 milliliters of 5 per cent Hog gastric mucin. 12 untreated mice were similarly challenged.

The untreated mouse which died on the third day showed no obvious inflammatory condition at autopsy and cultures from the peritoneal cavity and heart-blood were negative but there was extensive penetration of Haemoglobin into the tissues surrounding blood-vessels.

A human subject whose threshold agglutination titre to Staphylococcus aureus was 1 to 160, was given the staphylococcal lysate sublingually at the rate of 30 drops per day over three weeks. His agglutination titre at the 18th day was 1 to 640; 56 days later it had risen to 1 to 1440.

At the end of the first week, his serum was titrated against a number of strains of staphylococci other than phage type 80. This, unfortunately, was not thought of at the start.

Results were as given in the following:

TABLE IV

Period of Treatment	Strains of Staphylococcus V Aureus coagulase-positive			Staphylococcus albus from a bronchial infection
	Phage 80	"Oxford" Strain	Strain "M"	
At Commencement	1–160	–	–	–
7th day	1–320	1–320	1–320	1–80
9th day	1–320	1–320	1–320	1–160
18th day	1–640	1–320	1–320	1–320
30th day	1–960	1–640	1–480	1–480
56th day	1–1440	1-1280	1–560	1–480

What promised, at first, to be a more or less straightforward investigation became considerably complicated by two unforescen factors:

1. Antibodies to staphylococci were consistently evident in the serum of all guinea-pigs used throughout the tests.

2. Staphylococcal "lysins" present in the antigen employed in the complement-fixation tests interfered with the results obtained.

Regarding the first factor, the pooled serum of the untreated guinea-pigs (group 3) gave an agglutination titre of 1 to 40 against the formalised culture, a positive precipitin reaction against both the staphylococcal vaccine and the prepared antigen and, in the complement fixation test, similar evidence of Lysins v. Anti-lysins occurred as with the treated guinea-pigs.

It was, therefore, not surprising that administration of the serum from the control group afforded some protection to mice against the challenge with viable organisms, although to a lesser degree than that afforded by the treated groups of guinea-pigs.

In the complement-fixation tests lytic factors present in the staphylococcal antigen caused lysis of the haemolytic system beyond that of M.H.D. of complement employed in the tests, nevertheless, "fixation" of the complement by the test-sera could be demonstrated. It would seem that in the tubes in which the complement was completely "fixed" by the combined antigen and test-serum (but in which there apparently remained some unattached antigen-serum complex) lysis of the haemolytic system depended upon whether some of the lytic factors of the antigen remained un-neutralised by the anti-lysins in the test serum. As the lower dilutions of complement lysed the haemolytic system proportionately to the amounts of unfixed complement remaining after reacting with the antigen-serum complex, this assumption could not be verified, particularly as the complement itself was, as stated above, to some extent an anti-staphylococcal serum and presumably, therefore, contained anti-lytic properties, though in a lesser degree than that of the vaccinated groups of guinea-pigs.

Nevertheless, despite these anomalies, the degree of complement-fixation by the sera of the vaccinated groups of guinea-pigs was shown to be greater than that of the control group.

Preliminary immunization experiments showed that the sera of all groups of guinea-pigs gave protection to mice against the challenge dose of staphylococci. This necessitated reducing the

amount of guinea-pig serum given to a point where it became possible to distinguish between the protective power of the groups of sera. Finally, 0.1 milliliter of serum from each group, given 30 minutes prior to challenge, revealed that the sera of the vaccinated groups gave greater protection than that of the control group.

Sub-lingual administration of the vaccine to a human subject at the rate of 30 drops daily over a period of three weeks produced no side-effects, and the agglutination titre of his serum rose from a "normal" threshold of 1 to 160 to as much as 1 to 1440 against phage-type 80 with varying degrees of agglutination of other strains of staphylococcus aureus.

For the purpose of this investigation, one strain of Staphylococcus aureus (phage-type 80) was used throughout; a homogeneous lysate for the "vaccine", an antigenic extract for the complement fixation tests, and a viable culture for the challenge. To attempt to separate the various "fractions" comprising the lysate and to determine which of these were specifically antigenic or, indeed, which were at all antigenic, was well outside the scope of this investigation. Judging by the agglutination titres obtained with the serum of the human subject (Table IV), it would appear that such a homogeneous lysate could prove of greater value for the general purpose envisaged than would selected fractions, as the multitudinous strains of staphylococci which apparently comprise the species have certain antigens in common; as evidence the need for absorption techniques employed by the many workers who have, in the past, attempted serologic classification of this organism (from Koch:1908 to Mercier and others:1950).

Summary

Despite the intervention of certain unforeseen anomalies agglutination, precipitin and complement fixation tests have demonstrated that the administration by the oral route of an antigenic lysate of staphylococci (phage-type 80) to guinea-pigs provokes the formation of antibodies in the blood serum. This is confirmed by mouse-protection tests against a challenge dose of viable organisms in which 83 per cent of mice receiving the serum of treated guinea-pigs survived compared with 25 per cent survival rate of mice receiving no serum. A "natural immunity" to staphylococci was demonstrated in the control guinea-pigs, the serum of which protected 42 per cent of the mice similarly challenged.

Of the mice actively immunised with the staphylococcal lysate by the oral route, 83 per cent survived the challenge dose of viable staphylococci as compared to the 25 per cent referred to above.

Daily sub-lingual administration of the staphylococcal lysate to a human subject over a period of 30 days provoked a rise in agglutination titre of his serum from a "threshold" titre of 1 to 160 to 1 to 640 by the 18th day, reaching 1 to 1440 by the 56th day.

I acknowledge with thanks the helpful advice and criticisms of Dr. R. E. Derek Leigh and technical assistance and electrophoretic separations by Mr. R. Collins.

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56 Station Road

From the Columbus Hospital in Newark comes this very rare primary malignant liver tumor in a child.

Post Necrotic Cirrhosis of the Liver with Primary Hepatoma*

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Mathew M. Marano, M.D. / **Newark**

Primary hepatic tumors of children are rare. In Babies Hospital in New York City only twelve were found in a sixteen-year period.[1]

This tumor may occur at any age in children, and it is as common in girls as in boys. Apparently the low incidence of this lesion reflects the low carcinogenic potential of the liver. Carcinoma of the liver in children has been considered associated with embryonic cell rest.[2] In the first year of life, primary carcinoma is the most common epithelial tumor.[3] However, the liver offers a favorable site for the metastatic malignant cells of extra hepatic origin.

The commonest variety of liver tumors is the primary carcinoma or liver cell carcinoma. This particular variety is most common in boys under two years of age.[4]

A fascicle on tumors of the liver from many sources in the world has been excellently compiled for the Armed Forces Institute of Pathology. Here a classification[5] of these tumors is offered as follows:

1. Tumor-like epithelial lesions.
   a. Focal nodular hyperplasia.
   b. Multiple nodular hyperplasia.
   c. Accessory lobe.
2. Benign epithelial tumors.
   a. Adenoma.
   b. Adrenal rest tumor.
3. Cysts and tumor-like mesenchymal lesions.
   a. Mesenchymal harartoma.
   b. Non-parasitic cysts.
4. Benign mesenchymal tumors.
   a. Cavernous hemongioma
   b. Infantile hemangio-endotheliomas.
5. Teratoma.
6. Malignant tumors.
   a. Primary carcinoma
   b. Mesenchymoma
   c. Secondary tumors.

The most notable clinical feature is the enlargement of the liver. This is a common early finding. The mass is usually observed in the right side of the abdomen. Occasionally there is pain, weight loss, pallor, ascites (from partial obstruction), and, rarely, biliary obstruction causing icterus.

X-ray usually shows (in primary tumors of the liver) an oval shadow that extends downward from the right lobe.

A definite pathological diagnosis can be made only by biopsy. Aspiration biopsy is not usually recommended. The preferred surgical procedure is a laparotomy, where a satisfactory specimen can be obtained.[6]

Gross carcinoma of the liver in children is usually multinodular. These tumors are non-umbilicated. Areas of fatty change give a patchy pattern on microscopic study. They may contain a great deal of bile. The cells are more closely packed and smaller than in the adult type of primary hepatoma. Osteoids and area of calcification are common, which can be visualized by x-ray.

Differentiation of primary carcinoma of the liver, microscopically, may be difficult[7] when neo-plastic tissue must be differentiated from regenerative tissue; and primary, from metastatic carcinoma.

In the differential diagnosis, multiple causes of an enlarged liver or masses of the right upper

*This work comes from the Columbus Hospital, where Dr. Marano is attending pediatrics and Doctor Ritota is director of the Department of Medicine.

quadrant must be considered. Tumors can be diagnosed by direct biopsy. Wilms Tumors can be differentiated by intravenous pyelograms.

Neuroblastoma is distinguished from Wilms Tumors by its lateral and downward displacement, adrenal calcification, and its metastatic process.

Case History

A seven year old boy was admitted with a diagnosis of an enlarged liver. He complained of frequent epigastric pain and abdominal pains with anorexia, constipation and occasional vomiting of a few weeks duration.

Present Illness: According to the parents, this child was well until five weeks prior to admission when he started to complain of cramp-like pains in the right lower posterior thoracic area and in the epigastrium. During this period, he lost 2½ pounds in weight. His parents noted pallor, anorexia and constipation. Three weeks prior to admission, examination by the family physician failed to disclose a mass at all. At that time the child passed highly concentrated urine with acetonuria. By the time of admission, the enlargement had progressed so rapidly that hospitalization was advised.

Past History: He was always a strong and healthy child. He had had measles. He never experienced any major illnesses or diseases prior to this admission.

Family History: The father and mother are in good health. There is no history of any familial or metabolic diseases, nor any family history of cancer.

Examination: Temperature 99.6; pulse: 100; respirations: 24; blood pressure 96/60; weight. 50 pounds. He seemed somewhat malnourished, and the skin was slightly jaundiced and pale. He had moderate lymphadenopathy of glands of the posterior and anterior neck triangles.

Thorax was symmetrical and so were the respiratory excursions. The lungs were clear. The heart was percussed within normal limits, and there were no murmurs or friction rubs. There was a regular sinus rhythm.

The abdomen was slightly distended, more so to the right upper quadrant. A mass was palpable, about 4 fingers down in the right upper quadrant. This extended to the left upper quadrant. However, the mass in the right upper quadrant was multinodular whereas the mass in the left upper quadrant was smooth. Except for the glands of the neck, the rest of the lymphatic survey was normal.

Roentgenologic studies, by flat plate of the abdomen, showed enlargement of the liver. X-ray study of the chest revealed some elevation of the right diaphragm and no pleural or cardiac pathology. Bone survey showed no metastasis. Bone marrow studies revealed a normal granulopoesis. Erythropoetic responses were considered normal.

Course: Temperature ran a sustained level of 100° from the time of admission to the date of surgical biopsy. Up until this date he was treated with Demerol® and Vitamin K. Presumptive diagnosis was primary malignant hepatoma. Laparotomy revealed a massively studded liver with multinodulations, particularly in the right lobe. Further surgery was considered but no attempts were made. Post-operatively, he was given codeine for pain, and this was continued for several weeks. He continued to have anorexia and pain in the right upper quadrant. The abdominal distention continued to increase, and his temperature was sustained at 100° until thirty five days later when he died. During his hospital stay, he required only a half liter of whole blood.

Autopsy: The chief pathological process was neoplasia. The tumor cells were of hepatic cellular origin. Their hyperchromatic nuclei showed considerable anisonucleosis and poikilonucleosis. Occasional mitosis was present. Nucleoli were prevalent throughout. The tumor cells were arranged in irregular and distorted lobular fashion. Most of the normal architecture was completely destroyed. The normal liver parenchyma was replaced by dense fibrous connective tissue stroma sprinkled with lymphocytes and a few polymorphonuclear leucocytes. The stroma was infiltrated by small and large clumps of tumor cells. A few of the larger blood vessels appear plugged with groups of neoplastic cells.

Diagnosis: 1. Post-necrotic Cirrhosis of the Liver with Hepatoma.

Surgical removal has been attempted in recent years, since tumors can be removed if diagnosed early. Surgical removal has been more successful[8] since there is a better knowledge of the vascular bed and biliary system of the liver.

The interesting feature in this case is its rapid course. From the first examination by the family physician to the child's death was about eighty days. At the initial visit, no liver was palpable and at terminus the liver was 5 fingers below the costal margin.

Summary

A case history of a seven-year-old boy with primary malignant hepatoma was presented. The diagnosis was established pre-operatively and confirmed by direct surgical biopsy.
The rapid course of the progress of this malignancy was astonishing.

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99 Stuyvesant Ave.

Griseofulvin has been found effective in sporotrichosis and the deeper mycotic infections, as exemplified in this case.

Sporotrichosis Treated with Griseofulvin and Iodides

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Most of the reports on the use of griseofulvin in the treatment of mycotic infections have referred to the results obtained in the treatment of superficial types. Its use in deep mycotic infections has been limited because of the less frequent incidence of such cases and because the results of *in vitro* testing have not been favorable. A case of sporotrichosis treated with griseofulvin together with iodides is presented below.

Deep mycotic infections are sometimes seen in the New York City area. Sporotrichosis is uncommon in this vicinity. A number occur in suburban areas and eventually find their way to metropolitan hospital centers. The disease has been reported[1] as occuring in the urban areas of Brazil more frequently than in the countryside, contrary to what one would expect.

Recognition of sporotrichosis is, ordinarily, not difficult for the trained observer. Injury, usually to the hand, from thorns of rose bushes and barberry plants or from straw, is followed by the development of inflammation or ulceration at the site of injury. This lesion may heal, and subsequent swellings in chain-like fashion spreading proximally from the site of inoculation, usually on the upper extremity, are diagnostic.

The fungus is found as a saprophyte on plants. Inoculation into the skin is followed after a varying interval by a localized swelling of the subcutaneous tissues, discomfort, abscess formation, and ulceration. The chain-like nodules follow the course of the lymphatics; these vessels may be seen as red and elevated lines between the nodules, which may be hard or soft and are usually dusky-red in color, non-tender though occasionally painful. The nodules may soften or ulcerate after a period of several months to produce a purulent yellow discharge. There is some tendency to spontaneous healing, but as a rule the course is progressive and prolonged. In long standing cases the local lesions may become verrucous or fungating. Dissemination to other organs—such as the bones, joints, and lungs, either by direct extension or via the blood stream—is possible but rare; such cases[2] may not respond to the usual medications.

The causative organism is the Sporotrichium schenckii. The fungus is readily grown on Sabouraud's medium, and presents a characteristic picture: at first a white growth, smooth and shiny, which in time assumes a brown to black color. Specimens for culture may be obtained from the initial chancre, or aspirated from an abscessed nodule or from biopsy tissue.

There is a diagnostic skin test with the fungus

[1] *Florino de Almeda*, et al.: An Brasil. dermat. e sif. 30: 9, March 1955 Reference in yearbook of Dermatology and Syphilology Yearbook Publishers 1955-1956, Chicago.

[2] W. M. Mikkelson, R. L. Brandt, E. R. Harrell: Ann. Int. Med. 47: 435 (September 1957).

extract, sporotrichin, but the culture is more practical and may be more reliable. A positive skin test[3] may be found in non-mycotic dermatoses or in mycoses other than sporotrichosis or in previously infected but cured cases. Such positive reactions may exist in unrecognized or sub-clinical infections.[4]

For the treatment of sporotrichosis a saturated solution of potassium iodide in large doses is effective. It must be given over a period of time, even after all clinical signs have disappeared, since recurrence is possible. Not all cases respond equally well to iodides. Stilbamidine® and 2 - hydroxy - stilbamidine are advocated[2] for disseminated lesions, as has been Amphotericin.® Local treatment with iodides to the original lesion and to ulcerated nodules is also effective.

In view of the occasional case that does not do well with iodides, it was deemed necessary to try additional therapy. In this case griseofulvin was used.

A 68-year-old white woman was first seen in July 1961. She had suffered a laceration of the right thumb from a rose thorn in her garden one month previously. Two weeks later the thumb had become painful and swollen. "Lumps" had developed along the flexor aspect of the forearm which were red, swollen, and tender. There was no swelling, mass formation, or discomfort in the axilla. The process became progressively worse, but she felt well otherwise.

The right thumb was red, swollen, tender, and ulcerated and covered with a crust and oozing. The process involved mainly the dorsum, where there was an oozing lacerated area just above the nail. On the arm and flexor aspect of the forearm there was a string of four red, swollen, soft, and fluctuant nodes about the size of walnuts. These are seen in the accompanying pictures taken at the time of her first visit.

Material for a culture was taken from the ulcerated area on the dorsum of the thumb and by aspiration of a fluctuant mass on the forearm. The cultures were subsequently reported as growing sporotrichosis.

She was started on potassium iodide, 2.5 Grams in aqueous solution twice daily. Tincture of iodine was applied to the ulcerated area. Superficial x-ray therapy was given to the thumb. After one week she had improved only slightly. Griseofulvin tablets (500 milligrams twice daily) were prescribed in addition to the iodides. Within one week there was a marked improvement. Drainage from the thumb ceased and the nodes were smaller and less red: the original ulcer was healing. One month later the improvement was striking. There still was occasional discharge of pus from a wrist lesion. At the end of six weeks all lesions had healed completely. Medication was stopped at the end of two months. After three months the skin was less infiltrated, the nodes had flattened,





and movement of the thumb was more free. After four months she was symptom free. There was a slight pigmentation at the site of the nodes, and the skin on the thumb was soft. The patient was discharged as cured. There were no side effects from the medications used.

The use of griseofulvin in sporotrichosis has been reported earlier by various investigators. Blank and Roth[5] found that griseofulvin had no fungistatic action in *in vitro* studies on sprotrichium schenckii. Roth[6] pointed out that *in vivo* response may show entirely different results. Treatment with griseofulvin alone may not give complete healing, since griseofulvin is a fungistatic rather than a fungicidal agent. Supplemental treatment may be necessary.

[3]A. Padclla Goncalues and Lain P. Carvaltio: An. brasil dermat. e. sif. 29: 103 (June 1954).

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[6]F. Roth: Archives of Dermatology, 81:277 (May 1960).

Robinson and Roberts[7] felt that griseofulvin has little value in the treatment of sporotrichosis. Latapi and his co-workers[8] did report on the excellent results with the use of griseofulvin alone in a case of sporotrichosis on the face of a seven year old boy. Latapi[9] has reported four clinical cures in eight cases of sporotrichosis treated with griseofulvin with duration of treatment from two and one half to five months. Lyons[10] cited a case of sporotrichosis from straw used to wrap bricks. He was treated with griseofulvin, 500 milligrams twice a day. Within one week the ulcer had diminished 25 per cent in size. After three months of treatment, the patient was considered cured. X-ray therapy was used to aid in resolution of the locally infiltrated area.

It is possible that, in my case, good results would have been achieved with iodides alone; but the fact that the response was only "fair" after one week of iodides and "strikingly improved" after one week with griseofulvin cannot be overlooked. This improvement was more than coincidence. The use of griseofulvin in a series of cases of deep mycosis, particularly sporotrichosis, is warranted. Further reports may indicate its efficacy as a therapeutic agent in this class of infection.

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412 60th Street

Septic Shock.

Septic shock is defined as hypotension caused by bacteremia and accompanied by decreased peripheral blood flow, as evidenced by oliguria. Clinically, a shaking chill is the warning signal. The immediate cause of hypotension is pooling of blood in the periphery, leading to decreased venous return; later the peripheral resistance falls and cardiac failure may occur. Irreversible shock is comparable to massive reactive hyperemia. Reticuloendothelial failure, histamine release, and toxic hypersensitivity may be factors in the pathogenesis of septic shock. Adrenal failure does not usually occur, but large doses of cortisone are employed therapeutically to counteract the effect of histamine release or hypersensitivity to endotoxin. The keys to successful therapy are time, antibiotics, vasopressors, cortisone, and correction of acidosis.

A. M. Lansing
Canad Med Ass J 89:583 (Sept 21) 1963

Pigmentation In Antimalarial Therapy.

Localized, cutaneous, blue-black pigmentation of a unique nature, involving the pretibial, palantal, facial, and subungual areas, was studied in 25 patients receiving antimalarial therapy. Histopathological studies of 11 biopsies demonstrated melanin and hemosiderin to be present in all instances. Analysis for chloroquine in biopsies taken from pigmented and nonpigmented sites in three patients showed high concentration in all samples; a significantly greater concentration in the pigmented skin was found in only one patient. Four patients had retinal damage and eight had corneal depositions. Five patients were observed in the authors' clinic with retinopathy following antimalarial therapy; four had had cutaneous pigmentary disturbances prior to the retinal damage. Patients who develop pigment abnormalities when receiving antimalarial therapy should have frequent ophthalmologic examinations.

D. Tuffanelli, R. K. Abraham, and E. L. Dubois
Arch Derm 88:419 (Oct) 1963

Pain is not really pain until it is subjectively perceived in the cerebrum. Dr. Mettler here traces the central connections of pain.

Pain V:* Its Central Connections

Fred A. Mettler, M.D./New York

When the fibers of the dorsal root reach the cord there is a tendency for those of large diameter to be arranged dorsomedially and those of small diameter to lie ventrolaterally. Many of the former, which come from muscles and deal with proprioception, proceed directly into the dorsal columns and ascend to the nuclei of the fasciculi gracilis and cuneatus. The smallest fibers lie in the ventrolateral part of Lissauer's tract (called fasciculus dorsolateralis because of its position in the lateral white column of the cord) and establish connections with cells of the posterior horn for a distance of one segment rostral and one segment caudal to that of entry (three, and occasionally five, segments in all). The posterior horn contains a central nucleus proprius, a posteromarginal nucleus, capping this, and a cellular mass which forms the substantia gelatinosa, which lies on top of the posteromarginal nucleus. The posteromarginal nucleus receives fibers of the A group. Those of the C group end in all three nuclear areas, especially the substantia gelatinosa. A wide range of intraspinal connections are possible as a result of connection with these nuclei. The nucleus proprius and substantia gelatinosa send secondary fibers through the ventral white commissure to form the opposite lateral and ventral spinothalamic tracts. (There is no complete agreement about the identity of which nucleus gives rise to exactly which spinothalamic fibers.) The lateral spinothalamic tract is generally considered to be the pathway for temperature and pain (obviously it is not known if the thermal and algetic fibers arise from different cellular groups) and the ventral spinothalamic for light touch, but complete abolition of pain cannot be confidently anticipated unless almost the entire ventral half of one side of the cord is severed. There is a tendency toward somatotopic localization in the pain fibers. Those from the caudal parts of the cord lie dorsolaterally, and those from higher regions extend farthest into the ventral white column.

Post-tractotomy analgesia generally reaches a contralateral level of from 2 (in the cervical region) to 4 (in the thoracic region) segments below the level of section. It is known that severe cramping pain, which is sometimes encountered with the phenomenon of phantom limb (which pain can be alleviated by removal of the postcentral gyri), often is not abolished by even extensive ventrolateral section. Such cramping phantom limb pain seems to travel with the proprioceptive fibers in the dorsal column, a not unnatural association.

After tractotomy there is a tendency for analgesia to disappear in about 3 months. After about a year, half the patients not only are found to be again suffering from their original pain but they often then experience a new and severe burning pain.

Large numbers of fibers leave the spinothalamic tracts as these ascend the spinal cord and medulla. Relatively few fibers remain to enter the thalamus. The fibers which leave establish connections which are responsible for a wide range of reflex changes. If the spinothalamic tract is cut in the mesencephalon, distress is still experienced after painful stimulation of the body but the patient seems to have difficulty in localizing the origin of this distress. It is probably not surprising that such a primitive sensory

* From the Departments of Neurology and Anatomy at Columbia University, this paper is based on a talk to the Anesthesiology Staff Conference at the College of Physicians and Surgeons there, given May 21, 1963.

experience as pain should be closely integrated into other basic cord and brain stem functions and that the major suprasegmental contributions to its experience should be in the direction of the nature of localization and affectivity.

The fibers mediating thermal and painful sensations from the head enter the medulla in the trigeminal and, to a lesser extent, seventh, ninth, tenth, and eleventh cranial nerves. Their central processes course caudally in the spinal tract of the trigeminus and end in that part of the nucleus of this which extends from the level of the obex as far caudally as the fifth cervical segment. Light touch in the facial area is mediated by fibers which end in the chief sensory (pontal) trigeminal nucleus. Gross touch seems to be mediated through both the nucleus of the spinal tract and pontal nucleus. The most rostral part of the nucleus of the spinal tract of the trigeminus receives fibers from the oral region. As one moves toward the fourth cervical segment one encounters the representation of progressively wider concentric facial territory. Lesions of the spinal tract at the level of C I generally result in sparing of the nasolabial area, slight impairment around this, and loss in a strip extending from the chin through the ear and over the forehead (onion peel distribution). From cells in the central nucleus of the spinal tract, and also from the chief sensory trigeminal nucleus, trigeminothalamic fibers (ventral secondary ascending trigeminal tract) pass to lie medial to the region of the opposite lateral spinothalamic tract. An additional trigeminothalamic tract lies in the dorsomedial part of the pons and mesencephalon. This dorsal secondary ascending tract of the trigeminus arises from the chief sensory (pontal) trigeminal nucleus and is concerned with light touch. The algetic trigeminothalamic fibers end in the lateral nuclear group of the thalamus being particularly concentrated in the posteromedial part of this. The only lesions of the thalamus which have been found to reduce pain are those which have been placed in the centromedian nucleus which has long been suspected of being the locus of ending of trigeminal fibers. Most thalamic lesions not only do not abolish pain but may evoke the hyperpathia which characterizes the thalamic syndrome of Dejerine-Roussy.

The lateral nuclear group of the thalamus projects to the postcentral gyrus, but painful perception is not represented in the cortex in the same definitive manner as is vision. It has been mentioned above that ablation of the postcentral gyrus results in alleviation of the cramping pain of phantom limb. This effect is spoken of as an agnosia for pain rather than as analgesia since pain can still be recognized. The distress caused by pain can also be alleviated by frontal lobotomy, but lobotomy does not lower the threshold for pain. Even total unilateral decortication (often erroneously called hemispherectomy) does not produce contralateral hemianalgesia. While stimulation of the cortex may rarely produce experiences identified as painful this is not an invariable result, seems to require strong stimulation, and even those painful sensations which are aroused are of a rather special variety (tingling or pronounced paresthesias). Reports of this type have been encountered after stimulation of suspiciously wide areas, including not only the postcentral gyrus but also the superior parietal lobule, precentral gyri, and occasionally other regions.

Some comments require to be made with regard to current speculations regarding the theoretical constructs known as the "reticular system" and "limbic lobe," which have been marshalled to aid in the comprehension of certain nebulous aspects of painful experiences. This is not the place to go into the origin of the theories of the reticular system and limbic lobe which I have considered elsewhere[1]. From a practical point of view, the following observations currently appear pertinent. It has already been noted, in what has been said in this and previous papers[2], that pain is of several varieties, that several kinds of afferent fibers are concerned with the afferent conduction of these varieties, that these fibers make not only several different types of connections but that they do so over wide areas, that the cephalad conduction of such impulses is not solely by means of a direct non-communicating route but that the system, which contains conducting elements

[1]Mettler, Fred A. Annals of the New York Academy of Science, 96:687 (1962)

[2]Mettler. Fred A. Journal of The Medical Society of New Jersey, 61:10, 62, 113, 181 (1964)

of very different diameters, makes abundant connections throughout its upward course and that only a relatively small proportion of its fibers reach the thalamus. Most of the latter are of smaller diameter. Many of those fibers which leave the centripetally directed system establish connections with propriospinal systems. Thus they are able to set up widespread somatomotor and vasomotor responses, as well as other types of sympathetic manifestations. Such reflexes, in turn, are able to arouse an extensive background of afferent activity. The essential aspect of the theory of the "reticular system," with which we are here concerned, is that which rests upon the observation that diffuse centripetal conduction is able to arouse a dozing animal and desynchronize its alpha EEG rhythm. There is no question about the validity of these observations. There seems, however, to be little to recommend the introduction of a gratuitously conceptualized "system" (which suggests the existence of a structural entity which has never been clearly defined) in order to explain the observed facts. The concept of a separate reticular system is a supererogatory neurophysiological concept which has been superimposed upon what is already known about the diffuse nature of neural organization, and especially about propriospinal function. Pain is unquestionably one, perhaps the most important one, of the afferent systems which are able to activate neural structures which lie in the course of centripetally directed fibers. In the case of pain, those centripetally directed fibers which actually get to the thalamus are relatively sparse in proportion to the infratentorial mass of the algetic system. It follows therefore that any surgical or pharmacologic approach to the problem of pain must be designed with a view to a consideration of the many collateral ramifications and secondary connections of the basic apparatus.

The possible relation of the "limbic lobe" (that is, the rhinencephalon plus the cingulate gyrus) to pain depends upon the observation that olfaction is associated in macrosmatic animals with pronounced affective states. Such affective states may, in turn, become manifest in the form of motivation. In anosmic aquatic mammals, such as whales, the relative prominence of the cingulate cortex, as compared with the rhinencephalon, has given rise to the assumption that the elaboration of nonolfactory affective states takes place in this part of the limbic lobe. This speculation has been extended to the theory that the limbic lobe is the structural substrate of emotion in man and that complex psychic elaborations of affect occur in the cingulate region. Since pain has a pronounced affective component, there has been some tendency to search for an association between limbic lobe structures and the experience of pain. So far as I am aware, no concrete evidence in favor of such an association has been brought forward. There is no need to depend upon speculations about "limbic lobe" function to explain the proliferations of painful experiences which have bemused general practitioners for generations and which have long attracted the attentions of philosophers and, more recently, psychiatrists. The essential features of these elaborations have been reasonably well illuminated by philosophic inquiry, and the dynamic events have been productively explored by psychiatrists as has already been explained. Although admittedly still tentative, I believe the general practitioner will find these conclusions and technics more enlightening and profitable than an excursion into the prospects of "limbic lobe" theory.

630 West 168th Street

New Psychoanalytic Officers

The New Jersey Psychoanalytic Society announced that Dr. Howard Schlossman of Englewood has been elected president for 1964-65, and Dr. Lawrence Deutsch, also of Englewood, has been elected treasurer. The new vice-president is Dr. George T. Zavitzianos of Tenafly. Dr. Bernard German of East Orange remains as secretary.

Simultaneous ectopic and intrauterine pregnancy is exquisitely rare. To have such a combination where the latter survives to term after salpingectomy is almost unheard of.

Coexistent Intrauterine and Extrauterine Pregnancy

Charles Richard Walsh, M.D.
East Orange
J. Calvetto, M.D./Newark

This report is from the Department of Obstetrics and Gynecology, St. Michael Hospital, Newark, N. J.

Simultaneous intrauterine and extrauterine pregnancy (combined or heterotopic pregnancy) is a rare condition, said to occur once in every 30,000 pregnancies. To date there are only some 500 cases reported in the literature.

A 28-year-old gravida IV, para-I, abortions-II was admitted to St. Michael's hospital on December 28, 1962 because of "colicky" abdominal pain and a left adnexal mass. Her normal menstrual period was November 10, 1962. Her first pregnancy terminated in 1959 *via* spontaneous abortion at 18 weeks gestation, requiring curettage. Her second pregnancy also ended in spontaneous abortion at 12 weeks gestation. This also required curettage. In 1963 she had a normal pregnancy with a vaginal delivery at term. Patient was type O Rh positive. Her past medical history was uneventful except for an empyema with subsequent rib resection in 1935 and an appendectomy in 1946.

At laparotomy, a left tubal pregnancy was found. A left salpingectomy was done. At this time, the uterus felt soft and globular. Pathology report revealed a ruptured tubal pregnancy, middle third. A non-morbid asymptomatic post-operative course followed.

On March 28, 1963, she presented herself to her physician's office with a complaint of left lower quadrant pain. Examination revealed the uterus to be definitely enlarged, soft, consistent with a 14 week gestation. The patient believed herself to be pregnant. Aschheim-Zondeis was positive.

An x-ray on June 25, 1963 revealed a fetus. Pregnancy proceeded uneventfully, and on August 15, 1963, she was delivered of a term male infant after a mid forceps rotation. Post partum course was uneventful.

This is a case of a combined intrauterine and tubal pregnancy, where the intrauterine pregnancy survived to term after salpingectomy for the ectopic pregnancy.

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[1]Winer, A. E.; Bergman, W. D.; and Fields, C.: American Journal of Obstetrics and Gynecology 74:170 (July) 1957.

[2]Vasicka, A. I. and Brable, E. E.: Obstetrical and Gynecological Survey 11:603 (1956).

60 South Munn Avenue (Dr. Walsh)

STATE ACTIVITIES

Introduction of New President*

Ralph Siegel, M.D./Perth Amboy

Mr. President, officers and members of The Medical Society of New Jersey, distinguished guest, ladies and gentlemen:

It is my great privilege to present to this assembly the 172nd president of The Medical Society of New Jersey—Dr. Charles Calvin. He falls into that category of men whose simplicity of manner, innate modesty and gaiety of spirit make them stand out among their fellows.

This is the story of a man whose whole life may be summed up in the word "service." Born in 1895 in Nebraska, Charles Calvin received his elementary and secondary education in Perth Amboy, where he was graduated from high school in 1914. He worked as a stenographer and bookkeeper until 1917, when he enlisted in the U. S. Air Force. He served in France until 1919 as Sergeant Major in the 16th Aero-Squadron. For a time he was an aerial-gunner instructor on flying missions. On his return from overseas he spent two years as junior purchasing agent for Armour & Co. before entering George Washington University, where he received a B.S. degree in 1925. He matriculated at Tufts Medical College and received a Doctorate in Medicine in 1929.

By the time Doctor Calvin started interning in Newark City Hospital in 1930 he not only had served in a war as an aerial-gunner but had worked with patients as night-physician at Hood Rubber Company during his junior and senior years in medical school, and as house-physician at the West Quincy Hospital during his senior year in medical school.

Upon completion of his internship in 1932 he married Madelyn Nealon. The marriage was blessed with one daughter, Mrs. Joan C. Bayuk, a graduate of Northwestern University.

Since 1932, Dr. Calvin has practiced general medicine and surgery in Perth Amboy. He has been associated with the Perth Amboy General Hospital, rising through the grades to become Full Attending in Surgery. He has been active on all committees and for many years has been a member of the Medical Executive Committee.

Doctor Calvin is a Fellow of the American Academy of General Practice, a Fellow and past president of the New Jersey Academy of General Practice, and a Fellow of the American Geriatrics Society. He holds membership in the American Medical Association, the Middlesex County Medical Society, and the Association of American Physicians and Surgeons. He has been for many years Medical Director of E. I. DuPont deNemours plants at Perth Amboy and Linden, and Physician for the New Jersey Home for Disabled Veterans at Menlo Park, where he is also president of the Board of Governors. He has also managed to find time in a life of hard work and service to his fellowmen to become a thirty-second degree mason, to be a member of the Last Mans Club of the American Legion, and to be an active golf playing member of the Metuchen Golf and Country Club. On the golf links Charley is a tough competitor, shooting in the eighties, and a deadly competitor on the greens.

From the very start of his practice, Doctor Calvin has played an active role in the Middlesex County Medical Society, having provided leadership as President and on the Board of Trustees. He has also been active in the civil life of the community, having served as Board of Health Physician for Edison Township from 1932 through 1958 and as Medical Director of Civil Defense.

Even as Doctor Calvin applied himself to his practice, his hospital, his community, so he gave of himself to the activities of The Medical Society of New Jersey. Over the years he has served The Medical Society of New Jersey in a number of capacities, particularly as a member of the Judicial Council for ten years. Under his able guidance, the Committee for Political

*Remarks made May 19, 1964, at the annual meeting.

Action in Middlesex County was launched, and as chairman he has worked to determine how the best elements in medicine and its service to the public may be preserved and presented in the proper light.

In addition to his medical responsibilities, Doctor Calvin has been vestryman at Saint Peter's Episcopal Church in Perth Amboy. He thus follows in the footsteps of Robert McKean, rector of Saint Peters in 1761 and the first president and founder of The Medical Society of New Jersey in 1766.

But more than all this has been his direct, friendly and earnest approach to people and their problems. At meetings many of us have noticed the quizzical twinkle in his eyes when he rises, challenging the speaker and says, "Okay, now I'm not saying you are wrong, but let us look at it another way." He stands on that plane of truth which may be more questions than answers, on that level which renews individuality.

Doctor Calvin has worked hard to attain goals of scientific excellence, he has demonstrated the capacity of leadership and through all he has retained his balance and keen sense of humor. He has in great measure what Robert Frost so aptly described as the courage to "Bet your sweet life on what you are doing—to bet on yourself."

It is to Doctor Calvin we now turn as he enters upon his high office, confident that he will lead us well, and bring to fuller and wider attainment our work for the advancement of the standards of medical care and the true good of the people of New Jersey.

I have the honor and real pleasure of presenting to you a man known to you all—your new president, Doctor Charles Calvin.

Address of Retiring President*

Jerome G. Kaufman, M.D.

The wheel of time has completed its wide cycle, and, whereas last year it summoned me to enter upon the office of the presidency, now it bids me depart.

To divest oneself of the insignia of office and to surrender the day-by-day routines and details are physical gestures that are easily made. But the identification of oneself with the vital interests and concerns of our Society becomes so intimate through the days of service that I know that not for a long time, if ever, will I manage to acquire a relaxation of involvement. The presidency thrusts a man into the heart of the Society. It also puts the Society forever in his heart.

The core concern of all the activities of The Medical Society of New Jersey is to imbue and endue its members with aspirations and abilities that will enable them better to serve mankind.

To this end, the individual physician, through scientific studies and educational programs of all kinds, must be stimulated to achieve his true best as a person and as a member of the profession of medicine.

He must be safeguarded in the conditions under which he works, in order to insure that he will be free to make full use of his capabilities.

Finally, he must be helped to assume his proper and influential place in the civic and social concerns of his community, so that working with his colleagues, and his fellow citizens he may influence constructively his life and times.

All these purposes the Medical Society seeks and pursues, as the records of its programs and activities well demonstrate. But the Society as an organization cannot do the whole job. For final, effective accomplishment, every single member must hold himself personally responsible, in conformity with the Society's purposes, to make the most of his best, for his own satisfaction and benefit, and for the real good of his fellowmen.

Life is a gift which contemporaries necessarily share. We are all part of the life of our times and of the circumstances which prevail. We cannot live in any true sense in a situation of selfish unconcern and aloofness. John Donne has put it far more clearly than I can. He says:

*Remarks before House of Delegates, third session, May 19, 1964

"No man is an island, entire of itself; every man is a piece of the continent, a part of the main; if a clod be washed away by the sea, Europe is the less, as well as if a promontory were, as well as if a manor of thy friends or of thine own were; any man's death diminishes me, because I am involved in mankind; and therefore never send to know for whom the bell tolls; it tolls for thee."

Identified with our fellowmen as fellow sharers and builders of our life and times, we are destined together to produce and to experience whatever of good or of evil befalls. Let us strive mightily to bring about developments that are wholesome and happy, so that for us bells of grief will not be tolling, but caroling joy bells will ring instead.

As president, I take my leave with grateful heart and splendid memories. As a worker and a bell ringer, I am ready to sign up for as long as I can serve.

Your Historical Papers and Records are Needed . . .

'Gather your rosebuds while you may
Old Father Time is flying . . .'

Dr. J. Henry Clark of Newark reminded his contemporaries in 1867 as he concluded a report on the first half-century of the Essex District Society. "If each county in the State will collect now all that can be rescued from oblivion," he wrote, "a very valuable history of the medical men who have lived in New Jersey could be prepared, a history which could increase in value as years roll on."

Many have heeded his urging, as shelves of published proceedings attest. Some others may have new or additional information to add concerning members or activities of County Societies or the State Society.

Old Father Time is still flying and the history of a second century is nearing completion for the Bicentennial in 1966.

If you have papers or suggestions for supplemental data you would like included in the two-century History of the Society, please forward them to Dr. Fred B. Rogers, Historian, The Medical Society of New Jersey, P. O. Box 904, Trenton 08605.

1964 Golden Merit Awards

Following are the remarks of retiring President Jerome G. Kaufman on the occasion of the Eighth Annual Bestowal of the Golden Merit Award at the 198th Annual Meeting of The Medical Society of New Jersey, on May 16, 1964.

Life's deepest debts are always hardest properly to acknowledge. As President of The Medical Society of New Jersey, it is my cherished privilege this afternoon to attempt to convey to this year's recipients of the Society's Golden Merit Award the profound gratefulness of their colleagues and patients everywhere for life-long services ungrudgingly rendered

"Greater love no man hath, than he lay down his life for his friend" is a truth of universal acceptance. The men and women whom we honor today have done just that. Through the comprehensive and unlimited dedication of their time and of their talents, they have given their lives to the care of their patients. Like Abou Ben Adhem, each has by his life recorded himself as "one who loves his fellowmen." The proof of love is unselfish service, and unselfish service has characterized all our jubilarians for fifty golden years.

No one can attain greatness unless he finds some one or some thing to serve which he regards as more important than himself. We are in the presence of greatness here today because these men and women of medicine early in their lives recognized the health and happiness of other people as more important than themselves. Throughout their lives they have lived and labored in the service of that conviction. They have spent their lives in going about doing good. Only God knows the true extent of their wide benefactions. We who share some limited intimation of the good that they have accomplished acclaim them for it and offer them the tribute of our love and of our thanks.

If there is one crying need in the world today, it is for good and great men and women. We are favored by fortune that in this room we meet in the company of so many men and women of true goodness and greatness. We greet them with reverence and joy, and from our hearts we hail them for the inspiration and the richness of their lives and of their works.

It is our prayer, I know, that God will bless them for the gifts of their giving. It is likewise our prayer that, moved by their example, we may imitate their virtues and come some day to share such honor and happiness as now are theirs.

In your name and in the name of all mankind, I thank them. In your name and in the name of all mankind, I wish them abundant life and joy for many fruitful years.

RECIPIENTS OF THE GOLDEN MERIT AWARD

ATLANTIC COUNTY

David Bacharach Allman, M.D., 104 St. Charles Place, Atlantic City
Cesare Augusto Milano, M.D., 1 South Brighton Avenue, Atlantic City

BERGEN COUNTY

Parker A. Groff, M.D., 2750 Jefferson Circle, Sarasota, Florida
Herman Halpern, M.D., 143 Engle Street, Englewood
Alice Baldridge Lewis, M.D., 1 Gilbert Road, Hohokus
Percy Ralph McFeely, M.D., 242 Palisade Avenue, Bogota
Moses Sandler M.D., 2013 Center Avenue, Fort Lee
George Franklin Worcester, M.D., 220 Engle Street, Englewood

CAMDEN COUNTY

David Fuller Bentley, Jr., M. D., 300 Broadway, Camden
A. M. K. Maldeis, M.D., 108 West Collings Avenue, Collingswood
Roberto Principato, M.D., 519 Broadway, Camden

CUMBERLAND COUNTY

Charles E. Sharp, M.D., High and Main Streets, Port Norris

ESSEX COUNTY

James Stockdall Allan, M.D., 158 Gregory Avenue, West Orange
Morton Meyer Brotman, M.D., 212 South Orange Avenue, South Orange
*Herman Busch, M.D., 46 Johnson Avenue, Newark
William Wheeler Cox, M.D., 79 South Fullerton Avenue, Montclair
Kurt Felix Friedlander, M.D., 370 West Market Street, Newark
Lydia Bauer Hauck, M.D., 644 Stuyvesant Avenue, Irvington
John Herbert Hermann M.D., 197 South Centre Street, Orange
Royce Paddock, M.D., 347 Park Avenue, Orange
Alfred W. Wynder M.D., 654 Lyons Avenue, Irvington

*Awarded posthumously
Died — January 6, 1964

HUDSON COUNTY

Sydney Chayes, M.D., 980 Avenue C, Bayonne
George Ginsberg, M.D., 624 Bloomfield Street, Hoboken
Earl John Halligan, M.D., 254 Montgomery Street, Jersey City
Roland Joseph Lynch, M.D., 245 North Arlington Avenue, East Orange
Ferdinand James Pflug, M.D., 732 Hudson Street, Hoboken
Samuel Sidney Schept, M.D., 4505 Kennedy Boulevard, North Bergen
Harold Frank Tidwell, M.D., 106 North Lakeside Drive, Lake Worth, Florida

MERCER COUNTY

Barney Doibe Lavine, M.D., 630 North Clinton Avenue, Trenton
Paul Barringer Means, M.D., 41 Eastcliff Drive, Concord, North Carolina

MIDDLESEX COUNTY

Ralph James Faulkingham, M.D., 411 Lakeview Drive, Deland, Florida
Robert Lewis McKiernan, M.D., 75 Livingston Avenue, New Brunswick
Matthew Frank Urbanski, M.D., 148 Market Street, Perth Amboy

MONMOUTH COUNTY

John Edward Maher, M.D., 96 Third Avenue, Long Branch

MORRIS COUNTY

Harold S. Hatch, M.D., 209 Bangsberg Road, Port Charlotte, Florida

OCEAN COUNTY

Marie N. Soprounoff, M.D., 1309 Central Avenue, Lakewood

PASSAIC COUNTY

Herman Levy, M.D., 158 Lexington Avenue, Passaic
Angelo Carfi Linares, M.D., 371 Market Street, Paterson

UNION COUNTY

Howard Fauntleroy Brock, M.D., 417 West Broad Street, Westfield
Lawrence Greeley Brown, M.D., 173 Madison Avenue, Elizabeth
Arturo Raimondo Casilli, M.D., 618 Newark Avenue, Elizabeth
Isadore Stein, M.D., 817 North Broad Street Elizabeth
Martin Henry Stein, M.D., 60 Elmora Avenue, Elizabeth
Elmer Peter Weigel, M.D., 727 Watchung Avenue, Plainfield

OBITUARIES

Dr. Joseph Barr

Paterson lost one of its well-known general practitioners on February 24, 1964 with the death on that day of Dr. Joseph Barr. Born in Paterson in 1897, he rceeived his M.D. at Bellevue in 1922. He entered family practice in Paterson following his internship in 1924, and scrved the people of Passaic County both as a general practitioner and as an assistant in urology in St. Joseph's Hospital. In 1942, at the age of 45, hc closed his office and accepted a commission in the medical corps of the Army. At the conclusion of his tour of duty at the end of the war, in 1946, he returncd to Paterson and to his busy practice.

Dr. Edward Essertier

One of our state's senior practitioners, Dr. Edward Essertier, died at his home in Hackensack on March 18, 1964. Born in Arkansas in 1888, he received his M.D. at Bellevue in 1911. After interning at the Jersey City Medical Center, he applied for, and obtained a commission in, the United States Army. He served during World War I and returned to Bergen County in 1919 to enter private practice. Serving as a family doctor for some years, Dr. Essertier became increasingly interested in pediatrics, and took a two year residency in that specialty at the Roosevelt Hospital in New York City. A year after the American Board of Pediatrics was established, Dr. Essertier took and passed their examination and was one of the first pediatricians in New Jersey to be so certified. Dr. Essertier was active in many civic affairs, serving the Library Board, the Board of Education, and the Board of Managers at Bergen Pines.

Dr. Karl Goldstone

Dr. Karl Goldstone, who had actually studied roentgenology under Dr. Wilhelm Roentgen himself, died in Hackensack on April 13, 1964. Born in New York in 1880, he received his M.D. in 1904 at the College of Physicians and Surgeons (Columbia University). He began specializing in roentgenology in 1910 and was thus one of the pioneer radiologists in the State. He was a charter diplomate of the American Board in that specialty when it was organized in 1934.

Dr. Julius Newman

Jules Newman, as he was affectionately called, was one of the pioneer plastic surgeons in our state. Born in 1901 in Newark, he received his baccalaureate degree at Columbia College in 1923 and his M.D. from Tufts in 1927. After his internship, he went to London, England, to serve as a "registrar" (what we would call a "resident") in general surgery, then in plastic surgery. He returned to the United States in 1930 and entered private practice. He limited his work to plastic surgery. The American Board of Surgery had developed a subsidiary board in plastic surgery in 1938; but in 1941, this was recognizcd for the first time as a fully independent specialty. Jules Newman was awarded his diploma in plastic surgery from the newly established Board in its first year. During World War II, at the age of 41, he applied for a commission in the medical corps and operated plastic surgery centers at several Army installations. He was chief of plastic surgery at St. James and Beth Israel Hospitals in Newark, and was consultant in his field at the Rahway Hospital, at Clara Maas, Hasbrouck Heights, and Irvington General Hospitals.

Dr. Royal A. Schaaf*

One of the best known physicians in the State, Dr. Royal A. Schaaf, died suddenly on April 15, 1964, at the age of 72. A past-president of this Society as well as of the Essex County Medical Society, formerly chairman of the Medical-Surgical Plan, and a pioneer in the development of voluntary medical-society sponsored medical care insurance, Dr. Schaaf, though born in Iowa, devoted nearly all his professional career to northern New Jersey. He earncd his M.D. degree at Bellevue in 1913.

*For an editorial obituary on Dr. Schaaf, see page 171 of the May 1964 issue of this JOURNAL.

BOOK REVIEWS

Handbook of Psychiatric Treatment in Medical Practice. By Nathan S. Kline, M.D. and Heinz Lehmann, M.D. Philadelphia, 1962, Saunders. Pp. 124. ($3.50)

There is a need for a text on psychiatric treatment in general practice. Unfortunately, this book falls short of filling that need. In effect, what purports in the preface to be "a reasonably comprehensive operating manual for the medical practitioner"—"which provides insight into the fundamentals of psychiatric reasoning" is not comprehensive, is much too brief to be an operating manual, and does not provide insight into the fundamentals of psychiatric reasoning.

Actually, it is only a bare outline, which if condensed would fill no more than fifty pages. The section on neurosis could have been printed on one page. Of 124 pages, 28 were blanks (used to separate sections), and 11 were lists of drugs giving chemical, proprietary, U. S. A., Canadian, and British equivalents.

The authors make general statements, such as this one: He asks if all psychiatric patients should be treated by psychiatrists. "Very definitely not!" he answers, "the majority of psychiatric patients should *not* be treated by psychiatrists; there never will be enough psychiatrists; the cost of such treatment is prohibitive; and *the average psychiatric patient is better treated by the general practitioner or the specialist in some other discipline.*" He justifies the latter thesis by saying that the general practitioner is more familiar with the past history of the patient and his general medical condition. This suggests that the everyday psychiatrist can no longer elicit a medical history, that the general practitioner's past experience with the patient (if he has any) makes up for his lack of special skills and training, which this book says it can rectify.

A great point was made of the self-restituting qualities of the human being. Given proper surroundings and help pharmacologically, most patients—the authors say—will recover spontaneously, as in self-limiting diseases. It is true that some schizophrenic patients of the acute type do recover comparatively quickly, but it is doubtful that an encouraging word from the authors will immediately teach the general practitioner to be able to recognize them and make the differential diagnosis.

The general practitioner is encouraged to center his treatment on relieving symptoms and reducing situational factors through manipulation of the environment. The former is commendable, but the latter may be beyond the skills of the best social workers in many cases.

On the positive side. the book tries to encourage psychiatric care by the general practitioner with drugs, reassurance, family manipulation, and listening. It points up sharply the dangers of treatment of certain disorders such as the suicidal patient. It insists that psychodynamics ought not be approached except by the highly skilled specialist. The approach to the pharmacologic agents is the best part of the book. However, the authors—though well informed in this field—failed to give specific directions about the use of the drugs. Here they missed a fine chance to help the general practitioner toward what should have been, in my mind, the basic goal of this book. Allen Welkind, M.D.

Bray's Clinical Laboratory Methods. Ed. 6. Revised by J. D. Bauer, M.D.; G. Toro, Ph.D.; and P. G. Ackerman, Ph.D. St. Louis, 1962, Mosby. 142 illustrations ($10.50)

So extensively revised that it is virtually a new book, this sixth edition is not immediately recognized by those of us who used Dr. Bray's text as our constant companion and "vademecum." This is a practical presentation of the most frequently used methods of laboratory diagnosis. The form and content of the material are revised in this edition to conform with the requirements of the American Society of Clinical Pathologists. This reviewer does question the advisability of the chapter "General Rules: Laboratory Examinations of Value in Various Cases." Students and practitioners of medicine will not be guided by this outline; the general rules for medical laboratories condensed into but

ten sentences is all too skimpy and hastily done, since *Bray's* will be used in schools and colleges on medical diagnostic procedures.

This new edition contains the modern classification of the anemias and their investigations, using radioisotopes and Radioactive Vitamin B12. It has a new section that deals with immunohematology, karyotypes, and coagulation defects. A much needed chapter on blood grouping and cross matching has been included and a detailed discussion of the difficulties that may arise in each procedure and in their interpretation. Also is a discussion of fibrocystic disease of the pancreas, the newest pregnancy tests (Latex), and the fluorescence and millipore filter technics in cytology, a complete section on the serum lipids at this time of current interest in this subject.

The authors discuss new approaches in the investigation of atypical tubercle bacilli; pathogenic staphylococci, fungi and viruses; a quantitative method for fecal fat and steatorrhea; the chapter on blood chemistry contains approved methods which have been proven practical and are readily adaptable to any photoelectric colorimeter. There is included a chapter on toxicology, containing methods that can be performed in the average laboratory for phenothiazine, salicylates, isoniazids, barbiturates and PAS. This sixth edition is a helpful, practical reference that you can turn to with confidence, for assistance in explaining and discussing virtually all the frequently used clinical laboratory methods. Elmer Seachrist, B.S.

Financing Medical Care. By Helmut Schoeck. Idaho, 1962, Caxton Printers, Ltd. Pp. 314. ($5.50)

Schoeck, a sociologist at Emory, presents here estimates of the very different medical care systems in use in the United Kingdom, France, Sweden, Germany, Austria, Switzerland, and Australia. Each region is the subject of commentaries by several contributors, usually physicians personally familiar with the area. These commentaries are less concerned with financing practice (i.e., the kind of information which concerns claims agents, actuaries, and accountants) than with the problems and implications of the symptoms. Not all the problems are discussed (the complex maneuvering which "gets" the German doctor a maintenance insurance practice, the role of local Scandinavian politics and the influence it has upon who gets how much of the doctor's time, and the influence of the system upon the squeezing out of the individual Swiss surgeon are not elaborated), but the general impression with which Schoeck's commentators leave one is that the critical problems of all the European (and the Australian) areas are the same, and not very different from those which are shaping up the dominant medical center-foundation concept in the United States or our locally powerful corporation-executive patterned group practice. "Modern medicine in Germany is a large-scale scientific enterprise," says Korth, but it is obvious that the statement has universal application. It is a foregone conclusion, if one agrees to this statement, that not only the individualist in medical practice is doomed but so also is the patient as an individual (that he has already lost his individuality in the great teaching center, we all know). Unfortunately, the issue is larger than medicine and adds up to the conclusion that individuality will have to look to the arts and theology, to research and creative endeavor for survival. Fred A. Mettler, M.D.

Pediatric Surgery. By Orvar Swenson, M.D. Ed. 2. New York, 1962, Appleton-Century-Crofts. Pp. 779. Illustrated. ($20.00)

During his long service at the Boston Floating Hospital, Dr. Swenson established an excellent reputation as a pediatric surgeon. He is best known for his studies in the field of intestinal anomalies, especially megacolon, and his methods of care have served as successful guiding principles. In this book, the presentation of his material is excellent, the illustrations well chosen, and the art work by Ullrich is schematically and artistically pleasing and easily followed. The publisher has excelled in the clarity of reproduction of röentgenograms and in the general format.

The greater portion of the text is devoted to those subjects that exclusively concern children; but such fields as burns, fractures, and plastic

surgery are included. This reviewer would have appreciated a greater use of tabular presentation of etiology, frequency, mortality, and comparison of diverse surgical methods. A pediatrician would welcome a more up-to-date and comprehensive consideration of such strictly medical procedures as fluid replacement and antibotic therapy.

Dr. Swenson condemns the universality of circumcision. It is to be hoped that his next crusade will be aimed at tonsillectomy. In discussing the circumcision technic he does not mention the Gomco clamp. He states that "symptoms other than slight local discomfort are unusual in children with hernia." This reviewer has encountered *no* discomfort *ever*. He accepts (reluctantly to be sure) the yarn truss as a temporizing measure. Has anyone ever seen one work?

These remarks are merely intended to be pin pricks—certainly not adverse criticism of a wholly worthwhile work that belongs in the library of every general surgeon and pediatrician.

George Heller, M.D.

Congenital Malformations. First International Conference on Congenital Malformations. Philadelphia, 1962, J. B. Lippincott Company. Pp. 314. ($7.50)

This consists of a record of the International Conference on Congenital Malformation. All the disciplines involved in the study have contributed—including genetics, anatomy, pathology, immunology, embryology, obstetrics, and pediatrics. Much of the terminology may be esoterically new to the practitioner, but the volume has general value in that the ideas for the future are presented. New attacks on the age-old problems are presented and point up the path to be taken for further research.

The text begins with a discussion of the incidence and the differences from population to population and goes on to tie together the fragmentary and conflicting data inherited from the past. These follow a discussion of prospective, retrospective and analytic methods, laying groundwork for later papers.

Genetic factors including the intrinsic and extrinsic aspects are discussed, including chromosome abnormalities and the interaction of genes and environment in development. Teratogenic factors versus infections and cytoplastic actions are then reviewed. The book covers the transactions of eight sessions, each consisting of three or four papers. The sessions have the following headings: Intrinsic Factors, Extrinsic Factors, Incidence, Developmental Mechanisms, Maternal-Fetal Interactions, Physiologic and Medical Problems and Perspectives.

To oversimplify: the papers point up the fact that congenital defects take their origin from without or within the organism and are always the reflection of a failure in adaptability to novel conditions. This compilation makes for fascinating but difficult reading.

Ralph N. Shapiro, M.D.

Surgery of the Chest. By John H. Gibbon, Jr., M.D. Philadelphia, 1962, Saunders. Pp. 902. Illustrated. ($27.00)

During the last few months the world's medical literature has been enriched by several new books on thoracic and cardiovascular surgery. The most recent is this *Surgery of the Chest,* edited by Dr. Gibbon. This volume differs from the others in that it stresses the important details in surgery of the chest which can easily be forgotten to the detriment of the patient. This reviewer has observed these omissions in the work of some occasional thoracic surgeons, and it is for such a surgeon that this book should be most helpful. The 35 collaborating authors of each section of the book are not only eminent authorities in their field but are able to present their ideas with extreme clarity.

This reviewer found the section on cardiorespiratory dynamics during thoracotomy full of important and practical points. This material was presented in such a simple and concise manner that it should be of great interest, not only to the thoracic surgeon, but also to the anesthesiologist. The section dealing with the problems peculiar to infants is clear and practical and is certainly a "must" for those having occasion to do thoracic surgery on these delicate patients. In the net, this is a welcome addition to medical libraries and is highly recommended.

Adrian M. Sabety, M.D.

ABSTRACTS ON TUBERCULOSIS AND OTHER RESPIRATORY DISEASES. ISSUED BY THE NATIONAL TUBERCULOSIS ASSOCIATION

JUNE, 1964 • VOL. XXXVII, NO. 6

RESPIRATORY SYMPTOMS, LUNG FUNCTION, AND SMOKING HABITS IN AN ADULT POPULATION

In a community-wide study undertaken in Tecumseh, Mich., an association has been demonstrated between cigarette smoking and the common symptoms of respiratory disease.

In recent years there has been much interest in chronic nonspecific respiratory disease and, particularly, in the use of epidemiological methods to identify factors of importance in the development and progress of chronic bronchitis, emphysema, and related disorders.

In an attempt to identify factors relevant to the maintenance of health and resistance to disease, Tecumseh, Mich., was selected as the site of a comprehensive, prospective, epidemiological investigation of the entire community. Observations will be made over a period of years.

Tecumseh is a town of about 6,500 people. Included in the study also are some 3,000 people in the surrounding rural area. Data here reported were collected during a period beginning in March, 1959, and completed 18 months later.

Smoking Habits

Questions asked adults related to cough, production of phlegm, incidence of chest illness, and shortness of breath. A simple test of ventilatory function was included in the clinic procedures, a Collins timed vitalometer being used to record vital capacity and forced expiration volume—(F.E.V.1).

Information was sought about past and present smoking habits in adults. Cigarette smokers were subdivided into three groups—those using less than a pack, a pack, and more than a pack a day. The distribution into light, moderate, and heavy categories was about equal in the 1,400 men, but very few of the 888 women said they smoked more than 20 cigarettes daily, and light smokers were about twice as common as moderate ones. Present age was not related to daily consumption of cigarettes except at both extremes of the range where the proportion of light smokers was largest. Of the men, 260 smoked pipes and cigars only.

Smokers were also divided into three groups according to the length of time they had been smoking, the divisions being at 10 and 20 years. Duration of smoking was highly correlated with present age and attempts at assessing its effect on the development of symptoms have been limited by this fact. The finding is in keeping with other reports that the majority of smokers acquire the habit early in adult life. In all, 59 per cent of men and 34 per cent of women smoked cigarettes.

Fifteen per cent of the men aged 16 or more had never smoked, the percentage being highest in the very young and very old. Of the women, 55 per cent were nonsmokers, the percentage of nonsmokers being much higher above 50 years of age than younger.

In men the proportion of ex-smokers increased with age, but in women it was slightly lower in the oldest age groups.

MILLICENT PAYNE, M.D., D.P.H., and MARCUS KJELSBERG, Ph.D. *American Journal of Public Health,* February, 1964.

As for symptoms, persons who had both cough and phlegm, and one or both of these symptoms all day for at least three months each year, were designated as having Grade II symptoms; those with cough and phlegm to a lesser degree were designated Grade I.

The prevalence of Grade II symptoms in men who smoked cigarettes was six times that in nonsmoking men; the prevalence of Grade I symptoms was only twice as large. Among women, cigarette smokers had three times as much Grade II cough and phlegm and twice as much Grade I as nonsmokers.

Neither ex-smokers nor pipe and cigar smokers differed appreciably from the nonsmokers except in the oldest age group where the proportion with Grade II symptoms was less in nonsmokers. In the nonsmokers there was no appreciable difference between men and women in the prevalence of cough and phlegm.

The prevalence of symptoms increased with age in men who smoked cigarettes, being more marked for Grade II cough and phlegm than for Grade I. If this were an effect of age or of some experience associated with aging, a similar trend should be noted in nonsmokers. However, no trend of this type was seen in relation to Grade II symptoms among nonsmokers.

Shortness of Breath

In regard to shortness of breath, men cigarette smokers and ex-smokers were affected about equally and more often at all ages than nonsmokers. This suggests that smoking for prolonged periods of time may be related to the development of shortness of breath and that this is added to the effect of aging itself or of experiences associated with aging. Among the women, ex-smokers most commonly reported shortness of breath. Cigarette smokers had more shortness of breath than the nonsmokers below the age of 40 and less above this age.

In general, the percentage affected was largest in those smoking the most cigarettes and least in those smoking the fewest.

A comparison of the prevalence of shortness of breath by smoking class has been made in persons who did not have cough or phlegm. Ex-smokers of both sexes reported more shortness of breath than did any of the others, and among the older men cigarette smokers were more often affected than nonsmokers. Comparing cigarette smokers without cough and phlegm with all cigarette smokers, it is apparent that the excessive reporting of shortness of breath by the younger members of the group occurred in those who also had cough and phlegm.

F.E.V. Values

As for ventilatory function, men cigarette smokers had the lowest values at all ages and nonsmokers the highest, except in the youngest age group. Pipe and cigar smokers occupied an intermediate position and young ex-smokers had high values, whereas ex-smokers over 50 had low values. The mean values of F.E.V.1 in women hardly varied between categories.

In men the mean F.E.V.1 adjusted to the overall mean age of 40 years was 3.35 liters in nonsmokers and 3.12 liters in cigarette smokers; the corresponding values in women were 2.35 and 2.28 liters.

There are still unexplained differences in the relationship between cigarette smoking and respiratory symptoms; these include the higher prevalence of cough and phlegm in men than in women who smoked less than 20 cigarettes a day, and the low prevalence of cough and phlegm and shortness of breath in older women who smoked cigarettes.

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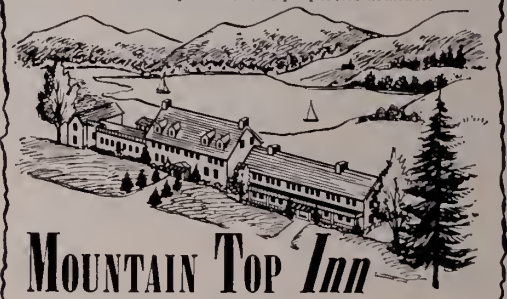
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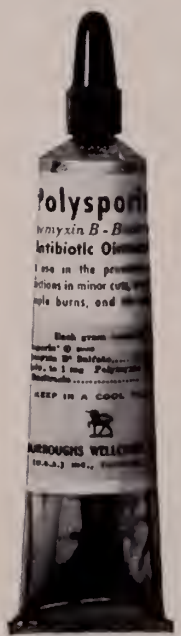
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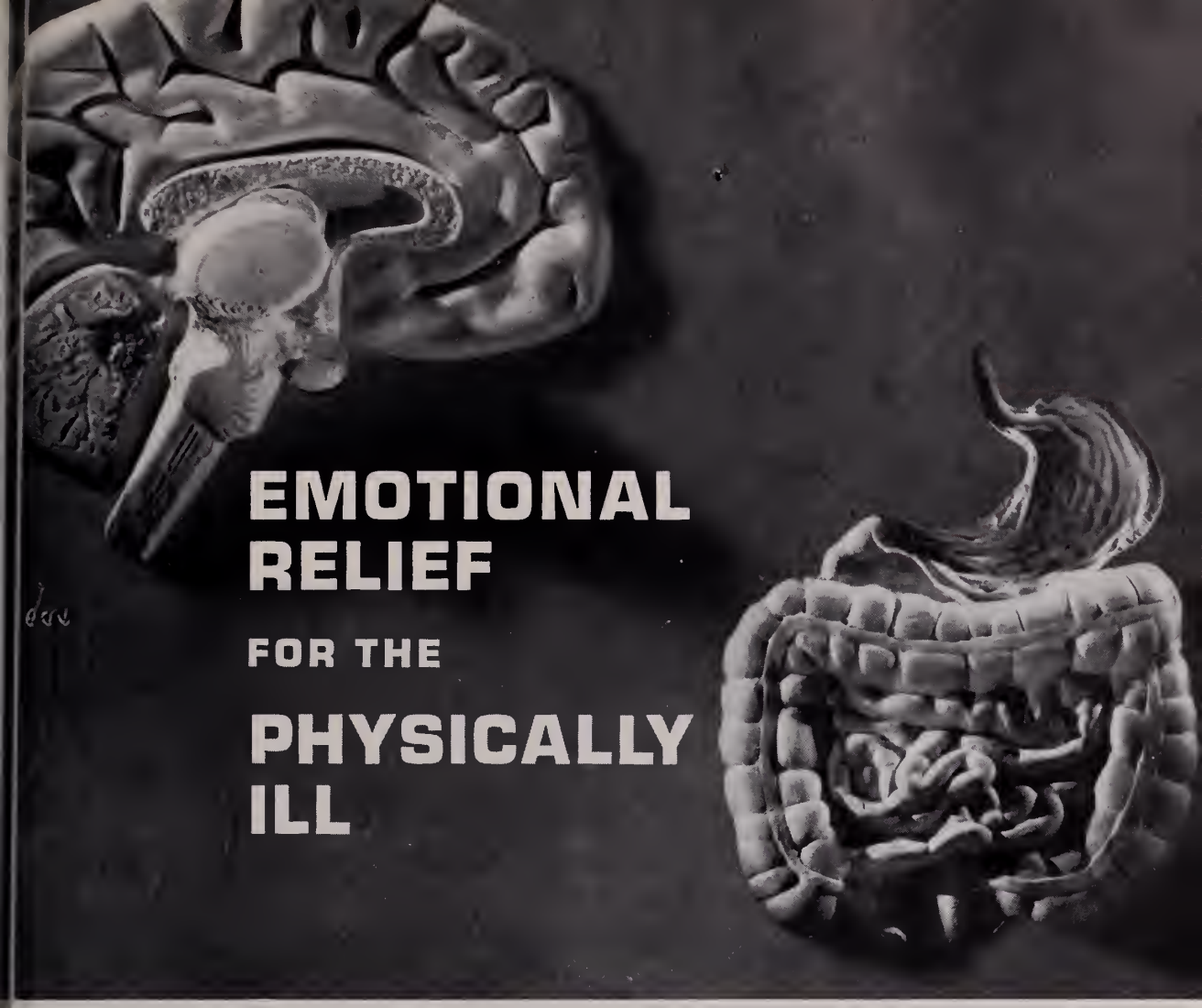
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[1] Simon, F. & Bernstein, A.: "The Treatment of Obesity in Patients with Cardiovascular Disease." Angiology, *12*:32-37, Jan. 1961.
[2] Plotz, M.: Modern Management of Obesity, J.A.M.A. *170*:1513-1515 (July 25) 1959.
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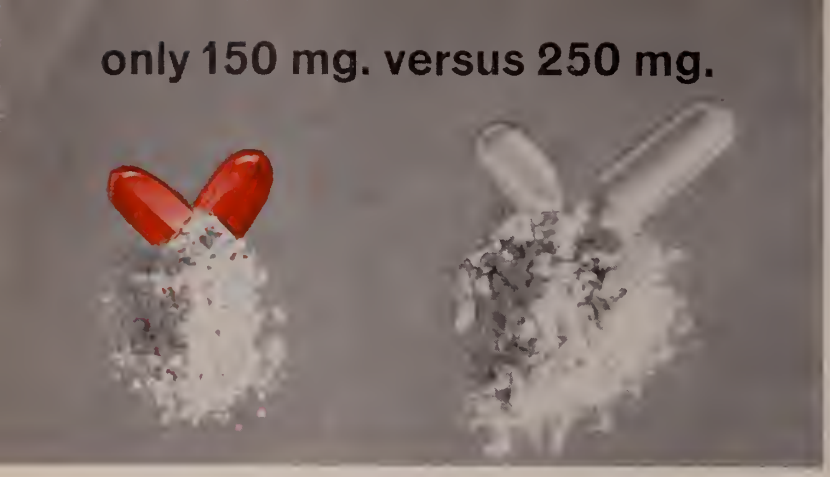
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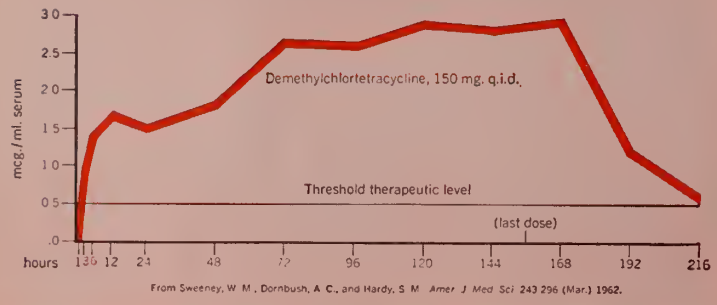
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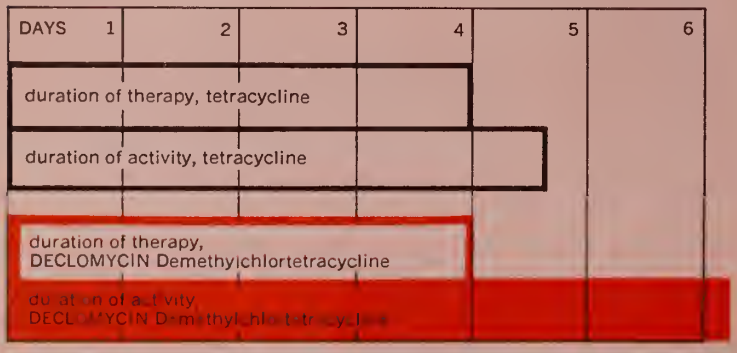


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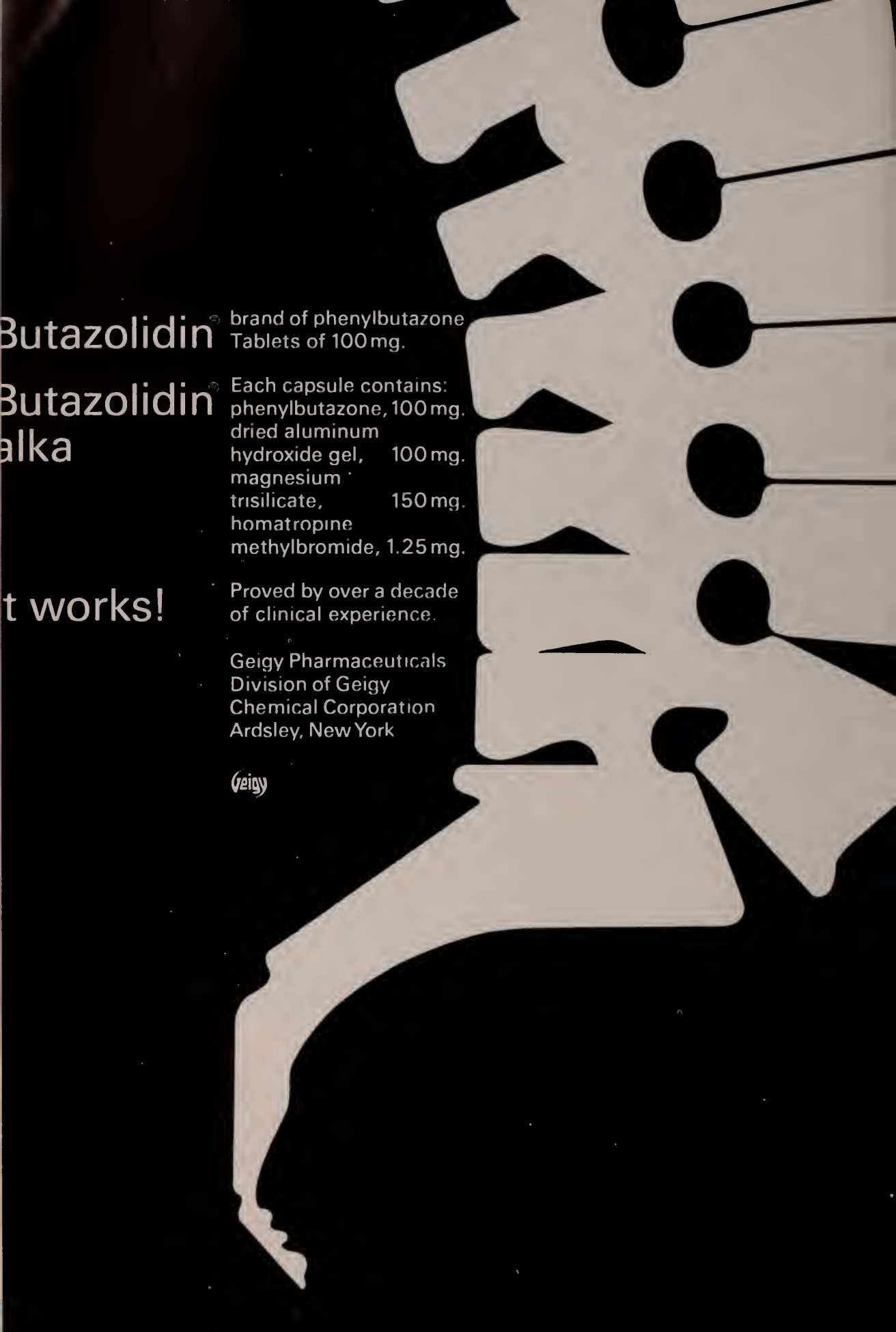
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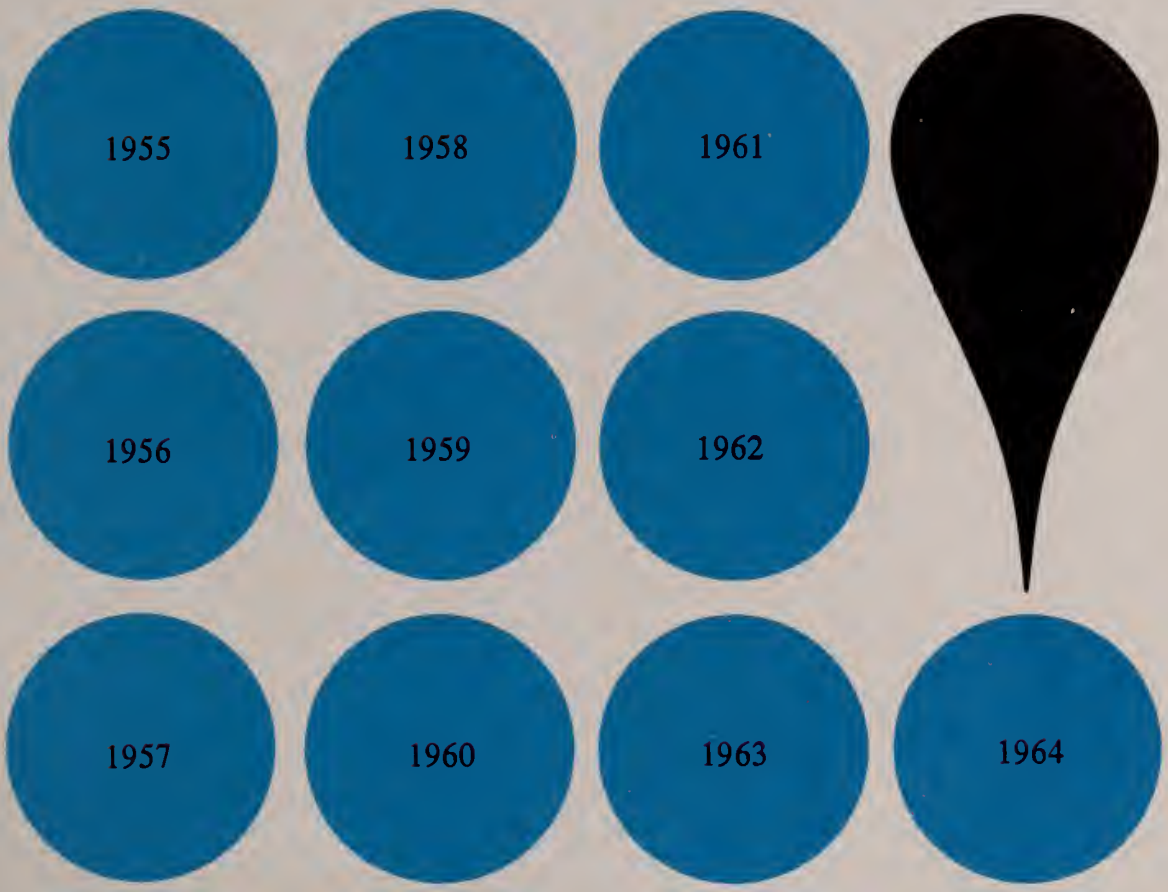
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1. Faludi, G.: J. Am. Med. Women's Assoc. 18,722, 1963. 2. W et al.: Scientific Exhibit, A.M.A., June 1962.

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2. A.P.C. compounds have limited usefulness; and the patient can buy them without your prescription. Unfortunately, most of them are too mild to be effective for sprains—and more potent products too often make the patient feel 'dopey'.

3. 'Soma' Compound is ideal in these cases. Since it contains both 'Soma' (carisoprodol) and acetophenetidin it is both a potent analgesic and a superior muscle relaxant; it also contains caffeine to offset any drowsiness *("numbs the pain... not the patient")*.

4. Why not try 'Soma' Compound? Dosage is 1 or 2 tablets q.i.d. For more severe pain, try 'Soma' Compound + Codeine. Dosage: 1 or 2 tablets q.i.d.

5. Hypersensitivity to carisoprodol may occur rarely. Codeine may produce addiction, nausea, vomiting, constipation or miosis.

Soma® Compound

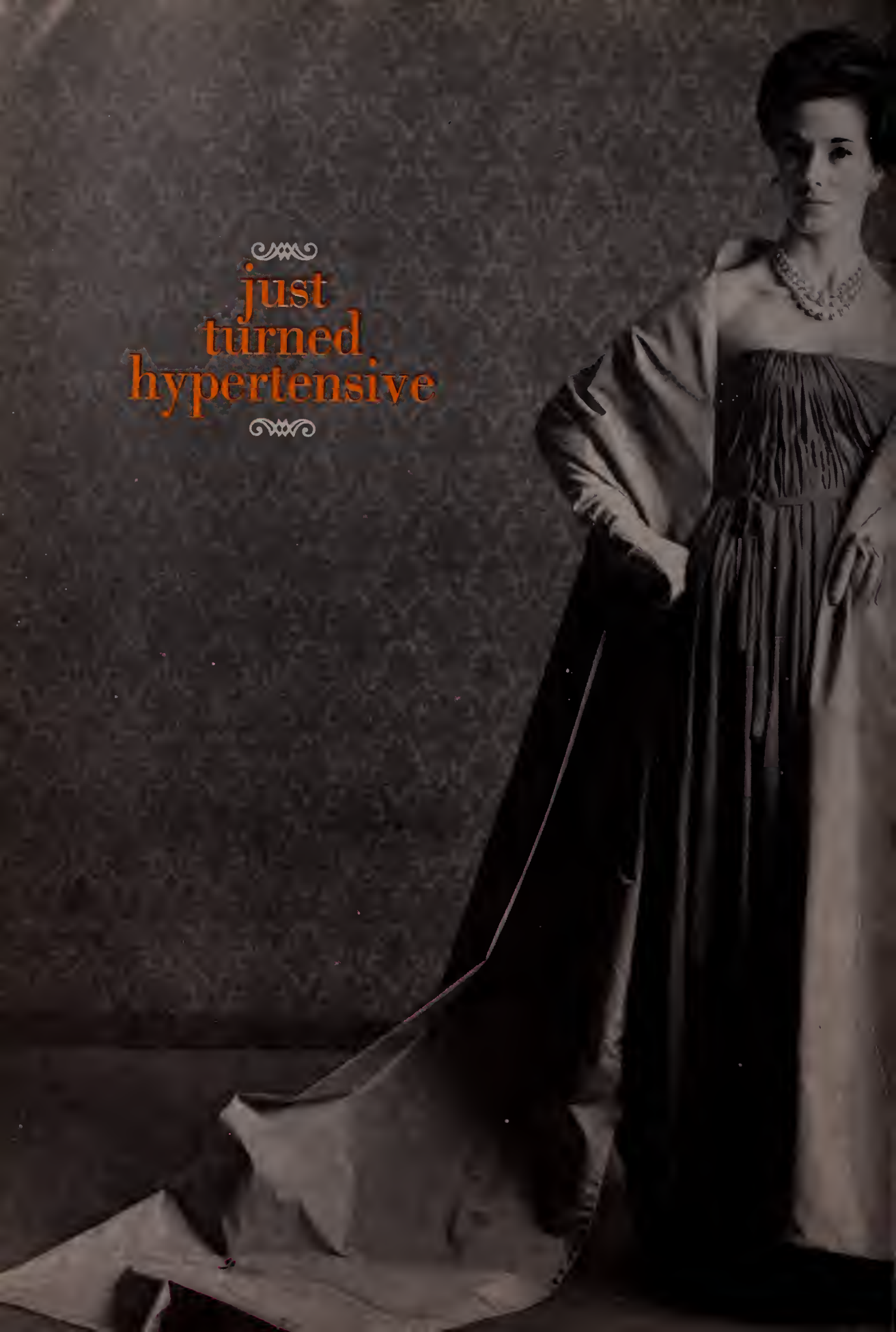
carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg.

Soma® Compound + Codeine

carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg., codeine phosphate 16 mg. (Warning—may be habit forming.)

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just
turned
hypertensive

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INDICATED in hypertension with or without edema, and in all types of edema involving salt retention. May be helpful in some cases of lymphedema, idiopathic edema and edema due to venous obstruction.

SIDE EFFECTS: Skin rash (rare), gastrointestinal disturbances, weakness and dizziness, seldom so severe that drug should be stopped. Generally, the adverse effects sometimes associated with the thiazide diuretics are possible. Pre·existing electrolyte abnormalities may be aggravated.

CONTRAINDICATION: Anuria.



1. Steigmann, F., and Griffin, R.: Evaluation of Quinethazone, a New Diuretic. *J. Amer. Geriat. Soc.* 11:945 (Oct.) 1963.
2. Schwartz, M.: Office Evaluation of a New Diuretic in Patients with Hypertensive Diseases. Scientific Exhibit Presented at the Clinical Meeting of the American Medical Association, Los Angeles, California, Nov. 25-28, 1962.

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"... their feelings of anxiety seemed to contribute to the urge to overindulge in cake, candy, and other rich food."[1]



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controls appetite all day long with a single morning dose

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Brief Summary of Principal Side Effects and Cautions

Side effects (chiefly nervousness and insomnia) are infrequent, and usually mild and transitory.

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Before prescribing, see SK&F Product Prescribing Information.

Supplied: Bottles of 50 capsules.

1. Viglione, J.P.: Clin. Med. *69*:1157 (May) 1962.

Smith Kline & French Laboratories SK&F

When you put patients on "special" fat diets..

you can assure them that no corn oil margarine is higher in polyunsaturates or lower in saturates than Mrs. Filbert's Corn Oil Margarine.

And once they've tried it, they can tell you that no margarine can match Mrs. Filbert's flavor.

Mrs. Filbert's Corn Oil Margarine is a special margarine* made from 100% corn oil, over 50% of which retains its liquid characteristics.

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For additional information, including detailed listings of component characteristics, please write to us: J.H. Filbert, Inc., Baltimore 29, Maryland.



* AMA Council on Foods and Nutrition: The Regulation of Dietary Fat, *JAMA* 181:411-423 (August 4, 1962).
AMA Council on Foods and Nutrition: Composition of Certain Margarines, *JAMA* 179:719 (March 3, 1962).

in



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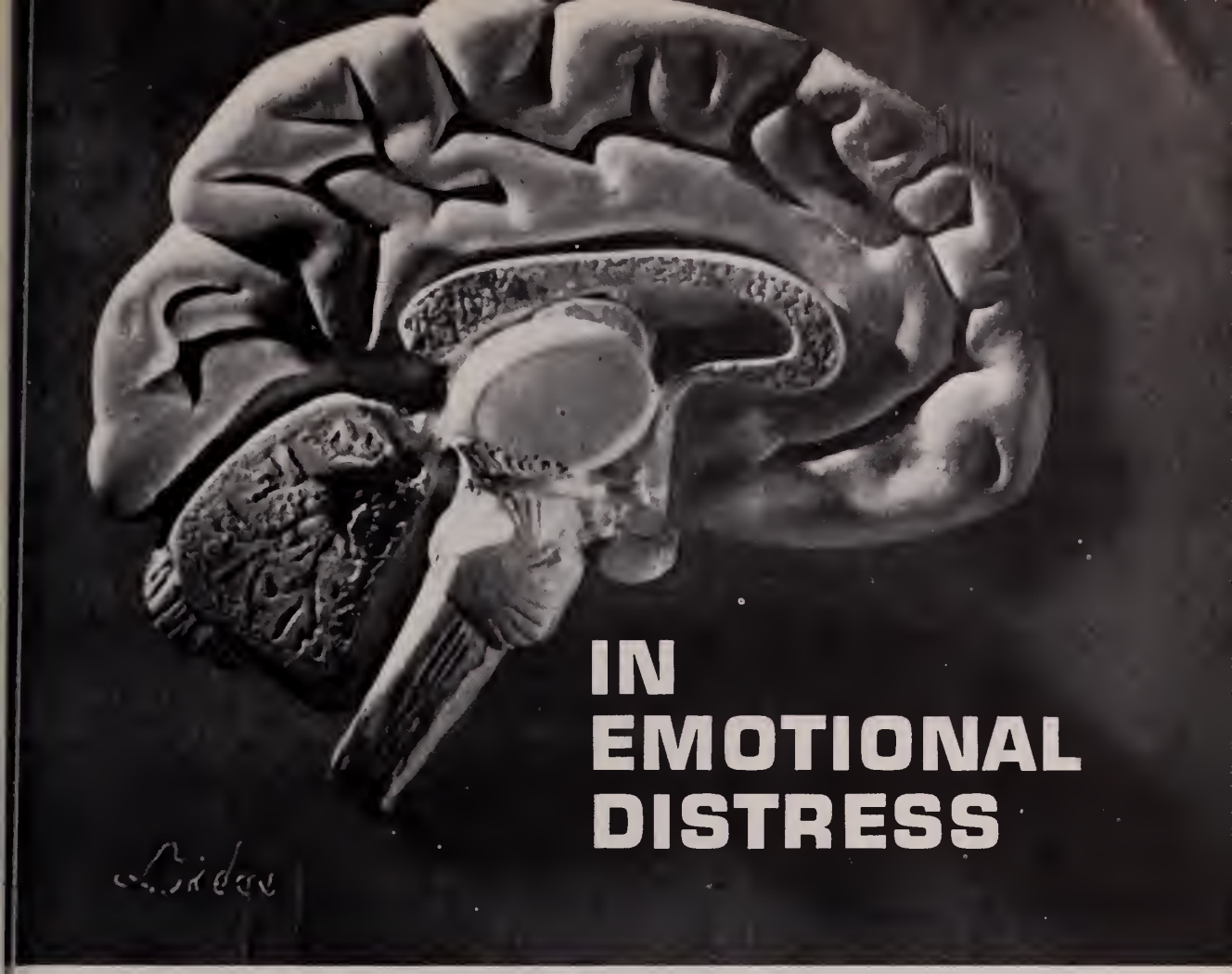
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■ **Anti-Bacterial Genteel Baby Bath** with 1% Hexachlorophene. Genteel provides excellent asepsis for infant baths, hand scrubs and continued anti-bacterial skin care at home.

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ELIEVES ANXIETY, APPREHENSION AND TENSION.



All day long
. . . keeps the patient calm,
and the mind clear.



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. . . aids restful sleep, with
no barbiturate hangover.

MEPROSPAN®-400
(MEPROBAMATE 400 MG. SUSTAINED RELEASE)

Simplified, convenient dosage for emotional relief.

effects: 'Meprospan' (meprobamate, sustained release) markably free of untoward reactions. Daytime drowsiness not been reported. Rare allergic or idiosyncratic reactions occur, generally developing after 1-4 doses of the drug.

traindications: Previous allergic or idiosyncratic reactions meprobamate contraindicate subsequent use.

cautions: Should administration of meprobamate cause wsiness or visual disturbances, the dose should be reduced. eration of motor vehicles or machinery or other activity uiring alertness should be avoided if these symptoms are sent. Effects of excessive alcohol may possibly be increased meprobamate. Prescribe cautiously and in small quantities to patients with suicidal tendencies. Massive overdosage may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after prolonged use at high dosage.

Complete product information available in the product package, and to physicians upon request.

Usual adult dosage: One 400 mg. capsule or two 200 mg. capsules at breakfast; repeat with evening meal.

Supplied: 'Meprospan'-400 (meprobamate 400 mg.), 'Meprospan'-200 (meprobamate 200 mg.), each in sustained-release capsules. Both potencies in bottles of 30.

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'METHEDRINE'® brand METHAMPHETAMINE HYDROCHLORIDE

is an easier way to help control food craving & keep the reducer happy

With "hunger pains" abolished, the patient can shrug off the chains of psychogenic craving that bind him to his habit of overeating and cooperate cheerfully with the prescribed diet.

In obesity, "...our drug of choice has been methedrine (methamphetamine hydrochloride)... because it produces the same central effect with about one-half the dose required with plain amphetamine, because the effect is more prolonged, and because undesirable peripheral effects are significantly minimized or entirely absent." Douglas, H. S.: West. J. Surg. **59**:238 (May) 1951.

Description: Each scored tablet contains 5 mg. 'Methedrine' brand Methamphetamine Hydrochloride.

Dosage: 2.5 mg. (½ tablet) 3 times daily. May be increased gradually according to response; more than 10 mg. daily rarely is needed. The last dose of the day should not be taken later than 6 hours before bedtime.

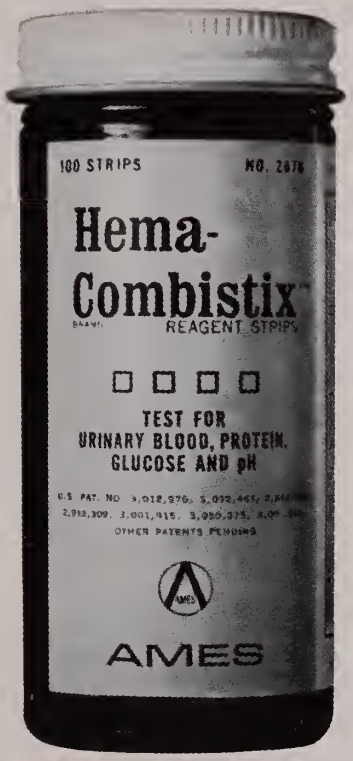
Side effects: Insomnia may occur if taken later than 6 hours before retiring. The usual peripheral actions of sympathomimetic amines (vasoconstriction and acceleration of the heart) are minimal and little noticed on low or moderate dosage.

Contraindications and precautions: Should not be used in patients with myocardial degeneration, coronary disease, marked hypertension, hyperthyroidism, insomnia or a sensitivity to ephedrine-like drugs. Moderate hypertension in the obese is not necessarily a contraindication since it may be relieved as the overweight is reduced.

Supplied: Tablets 5 mg., scored, in bottles of 100 and 1000.

Complete literature available on request from Professional Services Dept. PML.

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WARNING: MAY BE HABIT-FORMING

Once you have used **HEMA-COMBISTIX,**™ dip-and-read test for urinary blood, protein, glucose, and pH, it may become a habit to test every patient's urine routinely with this simple, convenient reagent strip. Most of the answers will be "negatives," but an unexpected "positive" may alert you to serious pathology even before related symptoms appear. The test takes only 60 seconds. As basic as the stethoscope...**HEMA-COMBISTIX** is a *good* habit to form. □ Ames Company, Inc., Elkhart, Indiana. 68764

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Putting the cap on a bottle sounds simple. Just make it tight enough to keep the contents in, prevent leakage, and protect the product; loose enough to be opened with ease. However, that isn't quite as simple as it sounds. ■ At Eli Lilly and Company, there are exact-tightness specifications for the cap of every bottle. Capping machines are carefully adjusted to apply just the right amount of torque (or twist) to tighten the caps. Then the tightness of the caps is double-checked . . . just to be sure. ■ That's where the torque tester comes in. At least once every fifteen minutes, five bottles are tested as they come out of the capping machine. They are placed on the torque tester, and the twist on the caps is measured . . . just one more of the many controls that add immeasurably to the quality of the finished product.

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EDITORIALS

Join the Blue Shield Survey Team

"Our voluntary system will survive," writes the President of The Medical Society of New Jersey, "only if we document its strengths and correct its weaknesses. Each doctor in this survey can make a unique contribution by participating in this project."

This is part of a nationwide survey to determine how effectively Blue Shield is measuring up to today's medical economy. Many of you have made complaints in staff rooms and hospital corridors. Here's your chance to register your opinion where it counts.

Known as the Nationwide Blue Shield Test of Performance Survey, the study will assess the extent to which Blue Shield fees are covering doctors' charges. The survey is being conducted by New Jersey Blue Shield.

A random sampling of recently paid claims is made, and the doctor is sent a questionnaire dealing with that case. Answering a questionnaire requires about one minute, through use of check-off boxes. Completed questionnaires are returned to National Association of Blue Shield Plans in a postage paid envelope that is provided.

The information provided by physicians is completely confidential; the portion of the questionnaire which identifies the doctor and the patient is torn off by the doctor before he returns the questionnaire.

The questionnaire refers to a specific case recently paid by Blue Shield, and asks the doctor: If he accepted the Blue Shield payment as payment in full for the services covered by Blue Shield; if not, what his total fee was, and the reason that the Blue Shield fee was inadequate; what his normal fee to the patient would have been in the absence of Blue Shield coverage, and two questions about his years in practice and nature of practice.

Pilot surveys in Alabama and Massachusetts this spring produced a 90 per cent return. Let us hope New Jersey will do at least that well. Since the sampling is a random one, some physicians will happen to have more than one case selected and may get more than one questionnaire. Please fill out all of them—since the forms are skeletonized to the point where a few check marks will do it. The results will provide valuable and honest data on the effectiveness of our voluntary system. Findings will be helpful in appraising fee schedules, types of contract and income limitations.

The House of Delegates of our Society has stressed the importance of your giving full cooperation in this survey.

Don't disfranchise yourself. Fill in the form promptly!

A Decade of Tranquilizers

Tranquilizing drugs, in the modern sense, first became available in 1954. To celebrate their tenth birthday, a symposium was held in New York City recently. Supported by a grant from Wallace Laboratories (Wallace makes Miltown®), the symposium was largely a paean of praise for these ataractic drugs. Thus, Dr. Michaelson found it advisable to "administer routinely meprobamate to all my coronary patients." Dr. Leake felt that the tranquilizers may "help in stopping, at the anxious stage, the psychodynamism towards disaster." Dr. Krantz enthusiastically hailed these drugs as "a new dimension in therapy when considered in their finer pharmacologic profiles." Another speaker characterized these drugs as "sedatives

which evoke relaxation without pronounced hypnotic action." Dr. Wroblewski found that tranquilizers "when fit into the mosaic of drug and surgical therapy contribute to better rapport."

The only faintly dissident notes were from Dr. Beckman, who feared that current federal safety regulations were a serious threat to further tranquilizer research; and Dr. Ayd, who was not entirely satisfied with our present inventory and said that there "is urgent need for additional tranquilizers."

If any of the speakers pointed out the disadvantages of living on tranquilizers, his remarks escaped the notice of your observer. We do know from the U. S. Department of Commerce that in 1962, at wholesale rates, more than 343 million dollars worth of tranquilizers and sedatives were sold. Translate that into retail prices and you have a lot of tranquilizers entering a lot of bodies.

One wonders why none of the speakers highlighted the withdrawal effects of discontinuing tranquilizers in a habituated patient. And, perhaps more important, the effect on society and civilization of drug-induced placidity. It may, indeed, be that anxiety is the divine spark that keeps us going. Great discoveries, inventions, and artistic creations do not come out of people who are smug and serene.

It is perhaps possible that a culture that has been soothed by solacing syrup of tranquilizers could fall prey to a civilization that is dynamically powered by its own discontent. There is something phoney about the instant happiness available at the swallow of a capsule. What is one doctor's placating prescription may be the patient's goof ball.

There are no short cuts to happiness, and the calm produced by a pill or capsule may be no more desirable than the relief that comes out of the liquor bottle. Is it, one wonders, the doctor's job to perpetuate the synthetic indifference of the tranquilizer-blanketed patient—or to help him face his problems more honestly?

Distaff Doctors

Several decades ago, about 4 per cent of entering medical students were women. Today the figure is about 8½ per cent. The same ratio appears on graduation day when the M.D. degrees are handed out—about 8½ per cent go to women. However, of all physicians in practice now, only about 6 per cent are women. This is not due to withdrawal of women from practice. It is simply that years ago the ratio was so much lower than 8½ per cent. Some women do withdraw because of marriage, motherhood, or moving with husbands to states where they are not licensed. But attrition for these reasons is not, today, very large. Many women doctors return to practice when their children reach school age.

The situation in the United States in this respect is almost unique. In the rest of the world, the ratio of females in the medical population is far above our 8½ per cent. Next door, in Canada, the figure is 12 per cent. In Great Britain it is 24 per cent. And in Eastern Europe it often exceeds 50 per cent.

According to the Association of American Medical Colleges, women significantly outscore men in some components of the Medical College Admission Test. It is hard to think of any field of medical practice in which women would be disqualified. If males can be successful gynecologists, why can't women be successful urologists? And females have been using needles and thread since childhood, so they ought to be better than men at putting in sutures and doing post-operative closings. There is no reason why females wouldn't make excellent dermatologists, pediatricians, and psychiatrists. We have in our country an enormous and largely untapped pool of women college graduates. In spite of this we are concerned about the shortage of medical school applicants. Someone ought to suggest more vigorous recruitment of women graduates. They could be a substantial increment to our reservoir of medical practitioners. And decorative, too.

198th ANNUAL MEETING
Haddon Hall, Atlantic City
MAY 16 - 20, 1964

Official Transactions Of the House of Delegates

THE MEDICAL SOCIETY OF NEW JERSEY

NOTE TO READERS

The annual reports and transactions of the House of Delegates of the 198th Annual Meeting of The Medical Society of New Jersey are bound together in this issue of THE JOURNAL. Actions taken by the House of Delegates are indicated in bold-face small type in the reports.

1964 TRANSACTIONS

At its first session on Saturday afternoon, May 16, 1964, the House of Delegates approved:

The Transactions of the 1963 House of Delegates as published in the July 1963 issue of THE JOURNAL and distributed to the membership.

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ANNUAL REPORTS

PRESIDENT

Jerome G. Kaufman, M.D., Maplewood

(Reference Committee "A")

The preparation of the report of the president is to me a bittersweet experience. It is sweet in the sense that the honor has been great and the opportunities to serve have been many and gratifying. What trace of bitterness tinctures it is all—and only—due to the fact that time seems so swiftly to pass, and one's accomplishments seem to fall so short of all that one had hoped to do. In this, however, the term of the presidency is much akin to the span of life—in prospect long, in retrospect all too brief.

As other presidents have intimated before me, the activities and operations of our Society are many and complex, and it is not until as president one is made part of all of them that he can appreciate how necessary it is—and how good it is—to have the advice and cooperation of fellow-officers, council and committee members, and dedicated and expert members of staff. To all who thus shared with me the burdens and challenges of my presidential year I offer my profound gratefulness.

Though the president does a good deal of travelling in the course of the year and of his participation in meetings and conferences of many kinds, my dominant recollection is of almost endless sittings. To a restive person—as I am told I am—it can be almost harrowing to have to sit through so much of discussion to achieve the inching progress that marks movement foreward toward the attainment of common goals. Perhaps Milton's line—as applied to conferences, at least—should read, "They also serve who only sit and wait."

Through the year, our intra-society councils and committees met regularly and with good results, as their reports reflect. We have also maintained all our liaison contacts—with other professions and with agencies of state government. We have striven assiduously to keep attuned to, and to function as a lively part of, the all-embracing operations of the American Medical Association. Likewise we have maintained close and cooperative contact with all our component societies.

Our liaison with the courts through our Joint Conference Committee with the Supreme Court of New Jersey has resulted in an expansion to state-wide scope of our panel system to supply impartial medical experts to serve at the call of the court. This year, too, we have carried forward, as of special and pressing concern, work on the "Proposed Guides for Physician-Hospital Relationships." We have established one new special committee, the Committee on Medicine and Religion.

It has been a very interesting and active year to me. I am richer because of the knowledge I have gained and the close contacts which I made with many officers and members of The Medical Society of New Jersey and of all its components. It is my heart-deep hope that when all that we have attempted and done can be evaluated at quiet levels of judgment, my year as president will prove to have been one of true worth and real satisfaction to our great Society, which I have been honored to serve.

Approved (page 324)

SECRETARY

Marcus H. Greifinger, M.D., Newark

(Reference Committee "A")

The office of the Secretary has continued its usual routines primarily involving correspondence, telephone inquiries, and completion of numerous questionnaires originating from various sources.

During the current administrative year the Secretary attended the annual meeting of the American Medical Association in Atlantic City —serving in a dual role as the Secretary and an AMA Delegate. At state level, the Secretary attended the meetings of the Board of Trustees and several committees of which he is chairman, member, or advisor.

MEMBERSHIP

(as of December 31, 1963)

Active: Paid	6,215	
Exempt	325	6,540*
Associate: Paid	446	
Exempt	47	493*
State Emeritus		148
State Honorary		4
New and Reinstated Members:		
Active	196	
Associate	257	453
Transfers within the state		32
Transfers out-of-state and resignations		60
Members deceased		84
Members dropped:		
Active (non-payment of dues)	30	
Associate (non-payment of dues)	15	45

*Adjusted for Transfers Out-of-State, Resignations, and Deaths.

AMA MEMBERSHIP

5,849 members of The Medical Society of New Jersey maintain active membership in the AMA. The Society's representation in the AMA House of Delegates continued to total six delegates—one for each thousand members, or fraction thereof.

It was noted that, of a total of 6,500 physicians, 5,849 members of MSNJ maintain active membership in the AMA. The Society's representation in the AMA House of Delegates is computed on the basis of one delegate for each thousand members, or fraction thereof. With the addition of 151 new active members in the AMA, MSNJ would gain an additional delegate. The reference committee urged that a strong effort be made to obtain this desirable increase in AMA members from New Jersey.

MEMBERSHIP DIRECTORY

Work is being carried forward to achieve the publication of a new edition of the Membership Directory in the fall of 1964. For a while it was hoped that the Society might be able to realize extensive reduction of publication costs by accepting a publisher's proposal to defray his costs by means of the use of advertisements. This proposition did not survive the period of detailed negotiations. In consequence, the new edition will be brought out on much the same basis as have earlier editions.

A number of new features will be embodied in the new directory, including:

A special section—available only in the copies prepared for members—which will supply the Constitution and Bylaws of MSNJ; the AMA Principles of Medical Ethics; the Legal Hazards of Medical Practice in New Jersey; and a list of Poison Control Centers in New Jersey.

In addition to the regular items carried in preceding editions, there will also be a classification of members by counties and towns; a list of county medical society office addresses; a list of honorary members; identification of emeritus and associate members; and each member's New Jersey license number.

Questionnaires supplied to the membership will form the basis for the biographical data to be published. With the cooperation of the membership, the committee hopes to make the forthcoming directory the most complete and most valuable version thus far produced.

Approved (page 325)

TREASURER

Daniel F. Featherston, M.D., Asbury Park

(Reference Committee "B")

The administrative and fiscal year of MSNJ is June 1-May 31. The following financial report covers the business transactions in the office of the Treasurer for the past twelve months, representing transactions of one month in the fiscal year 1962-63 and eleven months in 1963-64—in accordance with the suggestion that the report cover twelve months even though two fiscal years are represented.

This report, prepared and submitted by the auditor, covers the accounts from May 1, 1963, through April 30, 1964:

BALANCE SHEET — APRIL 30, 1964

ASSETS

Cash:		
First Trenton National Bank:		
General Checking Account	$68,114.33	
Executive Office Revolving Account	10,000.00	$ 78,114.33
Savings Accounts:		
The Bank of Commerce, Newark	10,000.00	
Bloomfield Savings Bank, Bloomfield	10,000.00	
The Broad Street National Bank, Trenton	10,000.00	
First Camden National Bank and Trust Co.	10,000.00	
First Merchants National Bank, Asbury Park	10,000.00	
First National Bank of Westville	10,000.00	
The Howard Savings Institution, Newark	10,000.00	
The Morris County Savings Bank, Morristown	8,716.17	
The Montclair Savings Bank, Montclair	10,000.00	
Plainfield Trust Company, Plainfield	6,232.82	94,948.99
Savings and Loan Accounts:		
Guardian Savings and Loan, Atlantic City	$10,000.00	
Midtown Savings and Loan, Newark	10,000.00	
Monroe Savings and Loan, Newark	10,000.00	
Police Savings and Loan, Newark	10,000.00	
Roma Savings and Loan, Trenton	10,000.00	50,000.00
Total Cash		$223,063.32
Accounts Receivable		5,257.59
Inventory—Maternal Welfare Record Books (at cost) (contra)		2,981.25
Investments—U. S. Savings Bonds and Treasury Bills		183,255.40
Land, Buildings and Equipment (contra)		152,491.40
Accrued Interest on Investments		982.63
Journal Deposit		500.00
Total Assets		$568,531.59

LIABILITIES, RESERVES, AND SURPLUS

American Medical Association—Education Research Foundation Payable	$ 30,240.86
Employees' Payroll Deductions Payable	1,431.43
Accounts Payable	133.90
Assessments Collected, Applicable to 1964-65 Fiscal Year	139,649.30
Unexpected Budget Reserve, 1963-64 Fiscal Year	42,046.92
Annual Meeting Reserve	29,619.95
Membership Directory Reserve	5,072.34
History Reserve—1966	5,000.00
National Welfare Record Books Reserve (contra)	2,981.25
Land, Buildings and Equipment Reserve (contra)	152,491.40
House Restoration and Replacement Reserve	1,277.16
Surplus	158,587.08
Total Liabilities, Reserves and Surplus	$568,531.59

STATEMENT OF RECEIPTS AND DISBURSEMENTS

May 1, 1963 — April 30, 1964

RECEIPTS — GENERAL FUND

Cash Balance, May 1, 1963 ..... $183,531.42

Assessments:	State Dues	AMA Dues	AMA-ERF	Total
Atlantic	$ 6,674.96	$ 7,110.00	$ 803.37	$ 14,588.33
Bergen	27,809.88	22,995.00	3,283.54	54,088.42
Burlington	5,226.67	5,580.00	625.03	11,431.70
Camden	15,079.96	16,155.00	1,783.39	33,018.35
Cape May	1,186.66	1,350.00	111.67	2,648.33
Cumberland	3,653.32	3,510.00	430.02	7,593.34
Essex	58,214.82	56,695.00	6,945.21	121,855.03
Gloucester	3,026.66	3,285.00	343.34	6,655.00
Hudson	21,741.68	21,285.00	2,483.38	45,510.06
Hunterdon	2,186.66	2,295.00	256.68	4,738.34
Mercer	16,046.59	17,482.50	1,740.08	35,269.17
Middlesex	13,139.94	14,197.50	1,598.43	28,935.87
Monmouth	14,499.84	12,355.00	1,351.77	28,206.61
Morris	11,253.61	12,285.00	1,305.04	24,843.65
Ocean	4,778.32	5,242.50	473.35	10,494.17
Passaic	22,306.65	19,295.00	2,720.04	44,321.69
Salem	1,740.00	1,935.00	215.00	3,890.00
Somerset	4,049.97	4,275.00	451.69	8,776.66
Sussex	2,966.65	3,150.00	180.01	6,296.66
Union	23,093.22	25,010.00	2,810.15	50,913.37
Warren	1,666.66	1,665.00	196.67	3,528.33
AMA Refunds		790.00		790.00
Total Assessments	$260,342.72	$257,942.50	$30,107.86	$548,393.08

Journal Advertising	$ 41,270.12
Annual Meeting Exhibits	25,035.00
Interest Income	7,987.67
Sale of Maternal Welfare Books	762.50
Transfers from Medical Student Loan Fund	59,120.00
Refunds of Budget Expenses 1963-64	3,517.87
AMA Dues Collection	2,535.65
Investments Redeemed (at cost)	208,166.20
Miscellaneous Receipts	268.10
Total Receipts	$ 897,056.19
Total	$1,080,587.61

DISBURSEMENTS — GENERAL FUND

Budget Accounts:		
A- 1 — Executive Salaries	$ 46,531.59	
A- 2 — Executive Office Salaries	53,044.37	
A- 3 — Executive Office Expenses	3,843.39	
A- 4 — Executive Travel	2,443.51	
A- 5 — House Maintenance	17,205.64	
A- 6 — Treasurer	3,599.28	
A- 7 — Finance and Budget Committee	69.77	
A- 8 — Secretary	1,629.70	
A- 9 — Salary Taxes	3,580.63	
A-10 — Insurance	3,302.87	
A-11 — House Reserve	10,881.04	
C- 2 — Council on Legislation	4,790.19	
C- 3 — Council on Public Health	2,266.93	
C- 4 — Council on Public Relations	6,998.54	
C- 5 — Council on Medical Services	685.71	
D- 1 — President and Presidential Officers	8,051.88	
D- 2 — AMA Delegates	7,852.17	
D- 3 — Woman's Auxiliary	2,747.50	
D- 4 — Committee on Medical Education	30.30	
D- 5 — Conference Groups	54.90	
D- 6 — Credentials, Membership, Directory and Physicians Placement	1,368.68	
D- 7 — Disaster Medical Services	53.63	
D-10 — Blood Bank Commission	250.00	
D-11 — Medical Defense and Insurance	194.90	
E- 1 — Board of Trustees	5,016.28	
E- 2 — Contingent	6,774.03	
E- 3 — Judicial Council	1,081.07	
E- 4 — Legal	6,845.37	
E- 6 — Medical Student Loan Fund Contribution	5,000.00	
Total Budget Accounts		$ 206,193.87
Transfer to Medical Student Loan Fund		65,620.00
Journal Publication and Expenses		63,138.22
Annual Meeting Expenses		20,809.24
AMA Dues Remitted		257,862.50
Assessments Refunded		1,885.33
AMA Dues Collection		2,541.18
Purchase of U. S. Treasury Bills		237,176.65
Miscellaneous Disbursements		2,297.30
Total Disbursements		$ 857,524.29
Cash Balance, April 30, 1964		223,063.32
Total		$1,080,587.61

MEDICAL JOURNAL

(Cash Basis)

May 1, 1963 to April 30, 1964

Budget Appropriation for Salaries and Taxes (contra) (1)		$ 9,997.79
Cash Receipts:		
Advertising—State Medical Journal Advertising Bureau	$26,139.39	
Advertising—Local	8,621.05	
Advertising—Classified	1,129.75	
Subscriptions and Extra Copies	1,191.48	
State Medical Journal Advertising Bureau Rebate	173.03	
Abstracts T. B.	440.00	
Decrease in Accounts Receivable	3,575.42	
Total Receipts		41,270.12
Total		$51,267.91

Cash Disbursements:		
Publication Costs	$47,655.89	
Journal Salaries (contra)	9,828.04	
Journal Office Expenses	924.79	
Journal Travel	529.61	
Discounts and Commissions—State Bureau	929.38	
Discounts—Local	254.37	
Commissions—Local	2,556.84	
Insurance	289.55	
Payroll Taxes (contra)	169.75	
Total Disbursements		63,138.22
Excess of Disbursements over Receipts		$11,870.31

(1) Disbursements include administrative salaries and taxes of $9,997.79 which were provided and paid from the general budget. They have been shown as expenses of the Journal operation in accordance with action of the 1963 House of Delegates. No transfer of funds has been made from the general fund to the Journal Operation.

Journal Accounts Receivable at April 30, 1964 total $5,257.59

MEDICAL STUDENT LOAN FUND

ASSETS

Cash:		
First Trenton National Bank—Checking Account*	$40,042.75	
First Trenton National Bank—Savings Account	4,304.21	
United Savings and Loan Association	10,000.00	$ 54,346.96
Notes Receivable—128 loans to 90 medical students		117,975.35
Fund Balance, April 30, 1964		$172,322.31

Fund balance includes $6,042.00 designated as the A. Barker Kump Memorial Grant and $1,430.00 as the Joseph E. Mott Memorial Grant.

STATEMENT OF CASH RECEIPTS AND DISBURSEMENTS

May 1, 1963 — April 30, 1964

Cash Balance, May 1, 1963		$ 58,222.74
Receipts:		
Budget Appropriation from General Fund	$ 5,000.00	
Interfund Transfers	65,620.00	
Contributions	6,199.50	
Interest on Investments	472.06	
Interest on Notes Receivable	71.64	
Collection on Notes Receivable	1,800.00	
Investments Redeemed (at cost)	14,767.94	
Interest on Savings Accounts	263.08	
Total Receipts		94,194.22
Total		$152,416.96
Disbursements:		
Loans to Medical Students—41 loans to 26 students	$38,950.00	
Interfund Transfers	59,120.00	
Total Disbursements		98,070.00
Cash Balance, April 30, 1964*		$54,346.96

*At April 30, 1964 a check drawn on General Funds is in transit to the Medical Student Loan Fund to clear interfund accounts in the sum of $37,298.90, and is included in the figures shown above.

Accepted (page 326), with commendation to the Treasurer and his staff for work and valor beyond the call of duty.

BOARD OF TRUSTEES

Samuel J. Lloyd, M.D., Chairman, Trenton

(Reference Committee "A")

Detailed minutes of the meetings of the Board of Trustees have been distributed monthly to component societies, for the full information of the membership. Summaries of the significant actions have regularly been highlighted in THE JOURNAL. Therefore, as has been the custom, this report of the Board of Trustees will cover only such items as are not reflected elsewhere in the individual reports of committees and/or councils.

The Society's business has made heavy demands upon the time of the Trustees. A total of twelve meetings will have been held prior to this annual meeting, each one lasting a full day. The Board members have served loyally and diligently. The councils and numerous committees have, by their work and endeavors, greatly facilitated the orderly conduct of the Society's business.

Routinely, the Board has dealt with general matters brought to its attention—correspondence and resolutions from members, component societies, and outside organizations; appointment of representatives to local, state, and national meetings of concern to this Society; nomination of candidates to the State Board of Medical Examiners; consideration of, and action on, the reports and recommendations of the councils, standing, and special committees; cooperation with the departments of state government and with the allied professions.

In an attempt to assist in the achievement of uniformity and conformity between the Constitution and Bylaws of MSNJ and those of its component societies, the Board was instrumental in evolving a model constitution and bylaws. This model was offered to component societies as a suggestion for those engaged in the revision of their constitution and bylaws.

In an effort further to serve the interests of all the members, the Board requested Legal Counsel to draw up a reference list of legal responsibilities of physicians practicing medicine and surgery in New Jersey, in conformity with the statutes and restrictions imposed upon by the state and its divisions, departments, and agencies. These "legal hazards" were condensed for easy reference and were published in the September and October issues of the MEMBERSHIP NEWS LETTER. They will also be included in the next edition of the MEMBERSHIP DIRECTORY.

As the result of replies from component societies to an inquiry from the Board, on a pilot study basis, presidents of component societies will be invited to an organizational meeting in Trenton on the same day as the October 1964 Board meeting. Scheduling of future meetings will be discussed and decided subsequent to the October meeting.

Approved (page 324)

BICENTENNIAL HISTORY

(Reference Committee "A")

The Board engaged the services of Mrs. Arlene R. Sayer of Trenton to prepare the official history of The Medical Society of New Jersey, for distribution in the late spring or early summer of 1966 in conjunction with the bicentenary of the Society.

Approved (page 324)

INTER-RELATIONS WITH THE JUDICIARY AND BAR

(Reference Committee "A")

The New Jersey Supreme Court has appointed an eleven man Committee on Relations with the Medical Profession—to continue the work previously done by its Advisory Committee on Impartial Medical Examination and Expert Testimony, and to expand the area of interest to include the mutual problems of the courts and the medical profession generally. Through the Administrative Director of the Courts, the Supreme Court invited MSNJ to appoint a corresponding committee of its members. Those named were:

E. Vernon Davis, M.D., Camden
Joseph P. Donnelly, M.D., Jersey City
Daniel F. Featherston, M.D., Asbury Park
John B. Fuhrmann, M.D., Flemington
Joseph M. Gannon, M.D., Plainfield
Marcus H. Greifinger, M.D., Newark
Jerome G. Kaufman, M.D., Maplewood
Samuel J. Lloyd, M.D., Trenton
Nicholas E. Marchione, M.D., Vineland
Jesse McCall, M.D., Newton
Richard I. Nevin, Ex-Officio, Trenton

Approved (page 324)

REPORTS OF AMA DELAGATES
(Reference Committee "A")

In disapproving resolution (#15) on the responsibility of AMA delegates, the 1963 House adopted the suggestion of the reference committee that some further implementation of the present method of reporting by the AMA delegates be considered. This matter was referred to the AMA delegates. Following each AMA meeting, the chairman of the delegates has submitted a detailed report to the Board of Trustees, which has been appended to the official minutes of the Board and thus distributed to component societies.

Approved (page 325)

D.O. TO M.D. CONVERSION IN CALIFORNIA
(Reference Committee "A")

The Board of Trustees had recommended to the 1963 House of Delegates "that any person fully licensed as a physician and surgeon by the State Board of Medical Examiners of New Jersey, licensed originally as holding a D.O. degree but who subsequently converted the D.O. degree to an M.D. degree through the California College of Medicine under its special program terminated on September 20, 1962, be considered to have an M.D. degree acceptable to this Society, provided that such person agree in writing to use the M.D. degree exclusively hereafter." The 1963 House of Delegates approved the recommendation of the reference committee that the recommendation of the Board of Trustees in this matter not be accepted:

(1) Until such time as the official body which we accept for the accreditation of medical schools approves the California College of Medicine specifically in its action of granting the M.D. degree to 2,100 graduates of osteopathic schools in July 1962; and

(2) Until the State Board of Medical Examiners qualifies one or more of these graduates as an M.D.

The 1963 House also approved the suggestion of the reference committee that the Board of Trustees and Society's Legal Counsel enter into consultation prior to taking any further steps aimed at implementing the recommendation.

In view of this action by the House, the Committee on Credentials notified the component societies that applicants with converted M.D. degrees would be ineligible for membership, by reason of their credentials. The Board referred this action of the House to Legal Counsel, with the request that he consult with the Deputy Attorney General for the State Board of Medical Examiners. Conferences have been held with him, and it is planned to have additional conferences for discussion of the matter.

Approved (page 325)

ACADEMY OF MEDICINE OF NEW JERSEY
(Reference Committee "B")

After investigation of numerous possibilities and possible sources of income without success, the Academy of Medicine of New Jersey appealed to the Board of Trustees for financial assistance to enable it to continue to maintain its library and services. The Academy estimated that between $15,000 and $20,000 would be required annually to maintain the library in its present status, improve certain conditions, and provide services in response to the 1,000 or more monthly requests from physicians for information and material.

The Board agreed that the matter needed exploration by both sides, and that any recommended action would have to go before the 1964 House of Delegates. The matter was then referred to the Committee on Medical Education for investigation and report and/or recommendations to the Board. After reviewing detailed information presented by the Academy, the Committee on Medical Education concluded that the Academy Library represents a paramount educational facility in the state and merits financial assistance. Thus, the Board of Trustees recommended a donation to the Academy of Medicine, which will

be brought to the attention of the House in the report of the Finance and Budget Committee.

Approved (page 326), with the recommendation that the House of Delegates approve a contribution to this worthwhile agency, and vote upon the merits of the request contained in the report of the Finance and Budget Committee (page 268).

GROUP HEALTH INSURANCE
(Reference Committee "C")

The appeal of Group Health Insurance against the Commissioner on Banking and Insurance, the Attorney General, Medical-Surgical Plan of New Jersey, and The Medical Society of New Jersey was held by the New Jersey Supreme Court on June 4, 1963. The Court was most attentive to the arguments and recognized the case as one of real significance in the field of prepaid medical service plans. Although it was impossible from the reaction of the Court to determine in whose favor they might decide, it was stated in the course of the argument by the Chief Justice that he felt the 51% requirement on a county basis was a higher percentage than it need be, and that the delegation by the legislature to the Medical Society rather than to a state agency or state agent was questionable.

In response to a specific question by the Chief Justice as to whether or not the 51% requirement is one "which could be met by a new corporation which might form under the existing action," the reply given in behalf of the Attorney General indicated that it "would be almost impossible to meet such a requirement." The Medical Society's defense in this action was greatly weakened by the position of the Attorney General on this point, in view of his primary responsibility for defending the constitutionality of the existing provisions of the action.

On July 1, 1963, the Supreme Court declared unconstitutional R.S. 17:48 A-2—pertaining to the approval of medical service corporation board members by an association of not less than 2,000 licensed physicians which has been in existence for at least ten years.

With regard to R.S. 17:48 A-3—pertaining to the necessity for 51% participation of licensed physicians in each county—the Supreme Court directed the filing of additional briefs and additional arguments.

Hearings and oral testimony were held on October 28, 1963, and completed on November 19, 1963. The matter was terminated with the submission of briefs and is now awaiting its consideration by the Supreme Court.

Approved (page 327)

MEDICAL-HOSPITAL LIAISON COMMITTEE
(Reference Committee "C")

Representatives of the New Jersey Hospital Association made it clear that they were as little satisfied as were the representatives of The Medical Society of New Jersey with the action taken by Blue Cross in connection with re-certification by the attending physician every 14 days of the patient's need for further in-hospital treatment. Inasmuch as there is, and should be, a close operating bond between Blue Cross and Blue Shield, it was the opinion of the liaison committee that in any discussion involving physicians in conjunction with the operations of Blue Cross, representatives of Blue Shield should be included in the conferences. In view of this, the liaison committee recommended to their respective organizations that, in future, all matters of this kind be discussed at a four-party conference attended by representatives of Blue Shield, Blue Cross, New Jersey Hospital Association, and The Medical Society of New Jersey. This recommendation was effectuated by expanding the membership of "The Permanent Committee on Blue Cross-Blue Shield." Originally its membership consisted of authorized representatives of The Medical Society of New Jersey, Medical-Surgical Plan of New Jersey, and Hospital Service Plan of New Jersey. Now representation has been accorded the New Jersey Hospital Association to make the committee an effective instrumentality for dealing with matters of concern to all four organizations.

A substitute for the 14-day re-certification is being studied which, it is hoped, will be acceptable to all concerned.

Approved (page 327)

MSP BOARD OF TRUSTEES—NOMINATIONS
(Reference Committee "C")

In view of the decision of the Supreme Court concerning the constitutionality of MSNJ approval of MSP Board nominees, there was some question as to whether or not such nominees should be approved by The Medical Society of New Jersey. Legal Counsel pointed out that approval by MSNJ is mandatory under the bylaws of Medical-Surgical Plan.

The following nominations were approved by the Board of Trustees and referred to the House of Delegates for action:

Three year term (1963-66) as the result of a change in MSP Bylaws which increased membership of the MSP Board from 23 to 25:

Robert E. Verdon, M.D., General Practitioner, Bergen County

Three year term (1963-66) to fill the unexpired term of F. Clyde Bowers, M.D., resigned.

Sidney I. Simon, Ph.D., Professor of Economics, Rutgers University

Three year term (1964-67):

Name	*Type of Practice*	*Member of Component Society*
Joseph P. Donnelly, M.D.	Obstetrics and Gynecology	Hudson County
Joseph I. Echikson, M.D.	Internal Medicine	Essex County
Jerome G. Kaufman, M.D.	Internal Medicine	Essex County
Joseph M. Keating, M.D.	Surgery	Passaic County
Elton W. Lance, M.D.	Surgery	Union County
Samuel J. Lloyd, M.D.	Surgery	Mercer County
Jesse McCall, M.D.	Internal Medicine	Sussex County

The Medical Society's Board of Trustees has noted that Medical-Surgical Plan has not yet presented nominees to represent the subscriber, as has been recommended previously. The Plan reports that it still has two vacancies to fill, and is in process of preparing further nominations.

For the record, the following are the remaining members of the Board of Trustees of Medical-Surgical Plan:

Royal A. Schaaf, M.D.	Surgery	Hunterdon County
Thomas J. White, M.D.	Internal Medicine	Hudson County
Rudolph C. Schretzmann, M.D.	Obstetrics and Gynecology	Bergen County
John S. Thompson		
Charles W. Barkhorn, M.D.	Otolaryngology	Essex County
Irving P. Borsher, M.D.	Internal Medicine	Essex County
Robert G. Boyd		
Charles L. Cunniff, M.D.	Internal Medicine	Hudson County
Andrew P. Dedick, Jr., M.D.	Radiology	Monmouth County
Duane E. Minard, Jr.		
Edward W. Sprague, M.D.	Surgery	Essex County
Charles O. Tyler, M.D.	Pediatrics	Camden County
Gustave E. Wiedenmayer		
President, The Medical Society of New Jersey		

Approved (page 327)

SUPPLEMENTAL REPORT

The following additional nomination for membership on the Board of Trustees of Medical-Surgical Plan of New Jersey for a three-year term, commencing with the Annual Meeting of the Plan to be held on May 26, 1964, was approved by the Board of Trustees of The Medical Society of New Jersey and is referred to the 1964 House of Delegates:

Edwin T. Ferren, D. O., Camden

Approved (page 327)

MSA BOARD OF GOVERNORS—NOMINATIONS
(Reference Committee "C")

The following nominations for membership on the Board of Governors of Medical Service Administration for 1964-65 were approved by the Board of Trustees of The Medical Society of New Jersey and are referred to the House:

Irving P. Borsher, M.D.
Harry N. Comando, M.D.
Royal A. Schaaf, M.D.
Rudolph C. Schretzmann, M.D.
Edward W. Sprague, M.D.
John S. Thompson
Thomas J. White, M.D.

Approved (page 259)

SUPPLEMENTAL REPORT

The sad and sudden death of our President, Royal A. Schaaf, M.D., on April 14, 1964, has created a second vacancy on the Board of Governors of Medical Service Administration of New Jersey; the first was occasioned by the protracted illness of Mr. Arthur W. Lunn. The following additional nominations for membership on the Board of Governors of Medical Service Administration for 1964-65 were approved by the Board of Trustees of The Medical Society of New Jersey, and are referred to the 1964 House of Delegates:

Joseph I. Echikson, M.D., Newark
Charles W. Barkhorn, M.D., Newark

Approved (poge 327). There wos discussion concerning the foct thot there ore no nominotions for either MSP or MSA from the southern counties. The reference committee wishes to bring to the ottention of the component societies the foct thot they ore privileged to moke recommendations to the nominoting committee of Medicol-Surgicol Plon ond Medicol Service Administrotion.

AMA INTERN APPROVAL PROGRAM
(Reference Committee "D")

The Board's resolution (#10) on this subject was accepted by the 1963 House of Delegates and referred back to the Board to encompass the intent of this resolution along with resolutions #2 and #3, into one or more resolutions that would be concise, brief, and effective for presentation to the House of Delegates of the AMA at the June 1963 meeting. The resolutions and the action of the House were referred to the AMA delegates with power to accomplish the House directive. Subsequent to the meeting, the revised resolution was sent to the AMA in Chicago and to the AMA delegates of the other 49 state medical societies, the intent of which was:

> Resolved, that the House of Delegates of the American Medical Association rescind that action taken in Los Angeles and re-establish educational and qualitative standards as the exclusive criteria governing the operation of, and admission to, approved intern and resident training programs in all hospitals, affiliated or non-affiliated, in the United States.

This resolution was successfully disposed of at the AMA meeting by the fact that the Council on Medical Education and Hospitals submitted —and the AMA House adopted—a revision of the "essentials of an approved internship" which "deleted the requirement for any stated proportion of foreign medical graduates and graduates of American and Canadian schools as an essential feature of any internship program."

Approved (page 328)

PROFESSIONAL SERVICE CORPORATION ACT
(Reference Committee "E")

The December 16, 1963, *Federal Register* contained proposed regulations concerning tax benefits available to professional people and announced a hearing on the proposed regulations before the Internal Revenue Commissioner in Washington for mid-January. Inquiry was received from the New Jersey Bar Association as to whether or not MSNJ would be represented at the hearing to contend that the proposed regulations would in large part negate the tax benefits made available to professional people through passage of the Professional Service Corporations Act in New Jersey, and should not be adopted. The official representative of the Bar Association selected to attend the Washington hearing offered to incorporate in his brief of opposition a declaration of the opposition of The Medical Society of New Jersey. On advice of Legal Counsel, the Board authorized the Bar Association representative formally to state for the Medical Society "that the proposed regulations appear to be unfair to professional persons in their denial of equal tax rights currently available to employees of business corporations, and, in that regard, that the same would appear to discriminate unjustly against the professional person."

Approved (page 330)

HEALTH FACILITIES PLANNING COUNCIL
(Reference Committee "F")

The Board was presented with a "Prospectus for Health Facilities Regional Plan" and the suggested bylaws for a proposed "Health Facilities Planning Council for New Jersey." The proposed council would be a non-profit organization, separately incorporated and completely independent of the New Jersey Hospital Association, its original sponsor. It would be composed of 21 persons representing groups and organizations especially interested in health facilities planning—such as The Medical Society of New Jersey, New Jersey Hospital Association, State Department of Institutions and Agencies, Hospital Service Plan, Health Insurance Council, Licensed Nursing Homes Association of New Jersey, organized labor, osteopathic physicians, and the public at large. The Board of Trustees was requested to name three representatives from the Society, to serve in their individual capacities, on the Board of Trustees of the council. The Board agreed that it would comply with the invitation, provided the person and participation of the designated representatives would not be construed as formally committing The Medical Society of New Jersey to sponsorship of the council until further investigation and study bring about a full understanding of the nature and operation of the council. On that basis, Doctors Louis F. Albright, Jesse McCall, and Louis S. Wegryn were named to serve.

Approved (page 331). Considered with Resolution #4 (page 317) and Resolution #7 (page 319).

HOSPITAL BYLAWS
(Reference Committee "F")

During the year the Board of Trustees considered numerous inquiries from its members as to how hospital bylaws might be amended, in consequence of the Greisman case, so as to eliminate any possibility of discrimination against individual applicants and to continue to protect the public interest.

The Board recognized that, in view of the decision in the case of Greisman vs. Newcomb Hospital, hospital bylaws can no longer require membership in a county medical society as a necessary qualification for staff membership. It unanimously agreed that, in its opinion, the following substitute requirement should be utilized:

"An applicant for a staff position must be a member of that professional society or association in which his doctoral degree entitles him to hold membership."

Approved (page 332)

The foregoing requirement, in the Board's opinion, would be valuable:

1. to hospitals, by reason of the fact that the qualifications of applicants for staff positions will all have been fully investigated and cleared by the credentials committees of the professional societies, as part of their procedure of admission to membership; and

2. to the public, by reason of the fact that membership in professional societies would insure to the public that hospital staff members are subject to, and controlled by, not only the exactions of civil law, but also the exactions of codes of ethical conduct and standards of professional deportment.

The Board considers that its foregoing suggestion to members concerning hospital bylaws is not in any way contrary to the court decision in the Greisman-Newcomb Hospital case. The defect in Newcomb Hospital's bylaw was the impossibility of compliance by an osteopathic physician. A bylaw in conformity with the Society's suggestion is possible of compliance by any licensed physician in New Jersey. The Board transmitted this opinion to the presidents of all hospital medical staffs in New Jersey.

House directed that copy be sent to the president and secretary of all medical staffs, hospital administrators, and hospital lay boards in New Jersey (page 332).

In a subsequent memorandum to presidents and secretaries of component societies, the Board requested that the information be brought to the attention of their members at regular meetings.

Approved (page 332)

IMPARTIAL MEDICAL EXPERTS
(Reference Committee "F")

On the basis of the pilot study in four counties of the first district made in December 1961—Essex, Morris, Union, and Warren— the Supreme Court extended the rule regarding impartial medical experts to cover the entire state, effective January 2, 1964. Request was made that panel members in the 17 categories be appointed by the Society. A communication outlining the program and requesting nomina-

tions was sent to 17 component societies on January 7, 1964.

Received as Information (page 332)

WELFARE PRESCRIPTIONS AND VENDOR VOUCHER FORMS
(Reference Committee "F")

A suggestion was submitted to the Medical Director of the State Division of Welfare that welfare prescriptions and M.D. vendor voucher forms be revised to include the practitioner's license number. Unless the practitioner's license number is noted on the form, there is no way for the pharmacist or welfare board to determine whether or not the bill should be paid. The State Division of Welfare, in reply, recorded it as their experience that most physicians do no memorize their license numbers, and the current prescription form requires notation by the physician of his U. S. Registration (narcotic) Number. Since most physicians know their assigned narcotic number, the Division suggested that they make mandatory notation of this narcotic number on all prescriptions or orders for welfare patients, with instructions to pharmacists not to fill welfare prescriptions unless such number is listed.

The Division of Welfare also requested assistance of the Board in connection with a physician's authorizing a prescription over the telephone and not providing the pharmacist with a written order. Since the pharmacist cannot receive payment from the welfare board unless he presents a signed prescription from the physician with his invoice, the Division must institute some control in this matter. The Board ultimately approved the following revisions of the vendor voucher forms, as recommended by the State Division of Welfare:

(1) requirement that the physician's New Jersey license number be recorded on the prescription form for welfare patients; and

(2) requirement that any physician who telephones a prescription for a welfare patient must himself deliver—or have his patient deliver—the written prescription to the pharmacist, before the medicine is supplied to a welfare patient.

Approved (page 332)

POLIO IMMUNIZATION
(Reference Committee "G")

New Jersey Commissioner of Health Kandle requested cooperation of The Medical Society of New Jersey in mass community immunization campaigns substantially to eradicate polio in view of the licensing of all three oral polio vaccines. The State Department of Health received a grant under the new Vaccination Assistance Act, to provide funds for staff to do laboratory studies, for assistance in community organization, and for working with those people "hard to reach" in such campaigns. The grant did not provide funds for vaccines or supplies, but the Commissioner reported that there was plenty of experience to demonstrate that such campaigns could—and should—be financed from costs assessed the people receiving the services. The Board of Trustees recommended to the component societies that they support the Department of Health in this important project. As of the present time, polio immunization campaigns have been conducted in every county of the state. The Society is in receipt of a letter from Governor Hughes expressing appreciation for the efforts of the members of MSNJ, in cooperation with the State Department of Health, for their united efforts in the "Victory over Polio" campaign.

Approved (page 333)

COMMITTEE ON MEDICINE AND RELIGION
(Reference Committee "H")

At the request of the American Medical Association—which reported that 31 states already had departments or committees on medicine and religion—a Special Committee on Medicine and Religion was appointed at state level, consisting of five members—one from each judicial district. This committee met with Rev. Dr. Paul B. McCleave, Director of the AMA Department of Medicine and Religion, who outlined the background and reasons for the establishment of such a department by the AMA, as follows:

To improve the total care of the patient by bringing together physicians and clergymen of all faiths for the study and discussion of their problems and common concern for the welfare of the patient.

Since the program can best be carried out at local level, it is the function of the state committee to give overall direction and assistance to the program within New Jersey, and to encourage each county to name and activate a similar committee. Since Bergen and Essex

Counties already have established committees, it was suggested that they be used as pilot programs, in encouraging other counties to get their programs underway. In furtherance of the goals of this committee, a special program on medicine and religion will be presented at this annual meeting, following the election session of the House of Delegates, on May 17.

Approved (page 335)

NURSING EDUCATION AND RECRUITMENT
(Reference Committee "H")

The 1963 House of Delegates approved the recommendation of the reference committee that a permanent committee on Nursing Education and Recruitment be established—in accordance with the suggestion contained in the annual report of the Special Committee on Nursing Education—consisting of representatives from The Medical Socicty of New Jersey, New Jersey State Nurses' Association, New Jersey Hospital Association, New Jersey League for Nursing, administrators of nursing schools and possibly advisors from the New Jersey State Department of Health. Such a committee was established; a report of its activities is separately submitted.

Received as Information (page 335).

EXECUTIVE DIRECTOR

Richard I. Nevin, Trenton

(Referencc Committee "A")

The experience that comes from the preparation of fourteen successive annual reports makes me realize that, like the ship's log of a widely-ranging vessel, the prosaic enumeration of the routines followed will, at best, reflect but imperfectly the adventures and the challenges, the shifting horizons and vistas, and hopes and fears that characterized our undertakings.

It has been a good year—not in the sense that all we sought and strove for was realized, but in the sense that we have maintained a steady course toward our professional and social goals and have had, in the aggregate, more accomplishment than disappointment, more frequent success than failure.

Thc Board of Trustees and the councils and numerous committees of the Socicty have faithfully, generously, and vigorously furthered our official programs and objectives, with specific results set forth in their individual reports submitted to the House. It has been my duty and privilege to be intimatcly a part of all the activities thus engaged in. As in the past, I have been impressed with the full measure of generous service which our officers and members give to their work for the Society, and I have been edified by the cnergy and carnest concentration of effort uniformly displayed.

I know of no area of our organizational operation that does not merit approbation. Thc balanced decisions and clearcut directives of the 1963 House have either been already implemented or are in process of implementation, thanks to prompt and efficient Board action. Thc Judicial Council is continuing its cxemplary work of maintaining a functionally distinguished judicial mechanism that will be a sourcc of satisfaction to all who come in contact with it. This year's Judicial Conferencc—calling together representatives of judicial committees of all component societies—contributed mcasurably to strengthening the mechanism.

The four administrative councils and their subordinate committees have well and faithfully carried on their functions through the year. Our AMA delegation is continuing its vigorous and effcctive work. Two new committees have got off to good starts—thc Committee on Medicine and Religion and the Permanent Joint Committee on Nursing Education and Recruitment. From their beginnings

of this year, we can look for distinguished accomplishments in the years to follow.

We have, by closer contacts and improved communications, worked through the year to coordinate more fully and efficiently our operations with those of our component societies. We supplied a Model Constitution and Bylaws to assist in this regard. Our goal is—through intimate, frequent, and friendly contact and conference—to strengthen our bonds, clarify our purposes and procedures, and, in general, establish a friendly and informal rapport that will insure unified and cooperative action. A good portent in this area exists in the plan to invite presidents of component societies to meet at the Executive Offices to discuss their problems and points of view, and also to join in meetings with the Board of Trustees.

In terms of pressure and pace of activities, this has been an exacting year in the Executive Offices. Illness has handicapped us at the level of both our officers and staff. We have been deprived since mid-February of the services of Mrs. Edith L. Madden, our stalwart Administrative Secretary and Convention Manager, because of her serious and protracted illness. We are hoping for her restoration to vigorous health and to our midst again. Meanwhile we are all doing our best to fulfill her assignments.

THE JOURNAL is a source of renewed pride to us all, and now that the work of reorganization and revision and revamping is moving to completion, we look forward to the realization of a quiet level of continuous and distinguished attainment. Our congratulations and thanks, and good wishes go to all who have shared burdens of THE JOURNAL's renaissance, especially to the Chairman of the Publication Committee, Dr. Sharbaugh; the Editor, Dr. Davidson; and the Assistant Editor, Miss Goeke.

As of last August we welcomed a new Office Manager, in the person of Mr. Robert H. Lambert. He has done a remarkable and efficient job since joining us and has been responsible for the introduction of innovations in operational efficiency that have simultaneously improved the quality and volume of our work output and streamlined working patterns. As a matter of fact, there is no member of our staff who does not merit a word of high praise and thanks. We have a collection of experts who, because of their skill and devotion, achieve prodigies of work of consistently high character. I am proud of and grateful to all of them.

My own work has been of a kind with the work of preceding years. All the business of the Society is my business, and to keep informed concerning it and effectively a part of it, leaves me little time to trifle away. From my diary totals I see that—apart from my regular duties as Executive Director—I have participated, in the course of the year, in 200 meetings and conferences, made 15 speech presentations, visited nine component societies, and made three out-of-state trips on Society business. I have worked in close cooperation with the Woman's Auxiliary throughout the year and am immensely gratified by the cooperation which the officers and members constantly give.

It is not alone by our efforts within the Society that our success can be measured and our status strengthened. We must—as we do—as an organization keep in touch with developments affecting medicine and the status of the profession, as these developments occur in other professional groups, in government, or in the areas of public interest and activity. Likewise our members, as individuals, must realize that our successful integration with the patterns of the social and community life of our times is bound up with the demonstration of our integrity as individuals. There can be no lasting social integration that is not based on individual integrity and worth. Nothing is rarer in life today than a person of unimpeachable intellectual, moral, and social integrity. If each of us concentrates on himself to effect and retain such integrity and worth, then we will be making a maximum contribution to the general good. Apart from the satisfaction that will follow in our personal lives, we will be extending the greatness of medicine as a profession and adding immeasurably to the life of our times.

Approved (page 325)

JUDICIAL COUNCIL

E. Vernon Davis, M.D., Chairman, Camden

(Reference Committee "A")

The Judicial Council has maintained its schedule of regular monthly meetings. From the official files, we present the following resume of its operations and those of its county judicial committees for the period April 1, 1963, to March 31, 1964:

BY THE JUDICIAL COUNCIL

Official communications acted upon	25
Appeal hearings granted	5
Formal opinions rendered	1

Interpretation of Bylaws: Chapter VII, Section 9—Penalties:
"Every county Judicial Committee shall have the power to censure, suspend, or expel any member of its Society for just cause."
(presented in full as an appendix to this report)

BY JUDICIAL COMMITTEES

Complaints reported as disposed of 54

Alleging:

Dissatisfaction concerning fees	34
Unprofessional conduct	9
Unethical conduct	2
Dissatisfaction with services rendered	9

REGULATIONS

In fulfillment of its regulatory powers under the Bylaws, the Council completed the revised version of the "Regulations" governing the judicial mechanism—which were first issued in 1956. The revised version has been distributed to the chairmen of all county judicial committees.

JUDICIAL CONFERENCE

On November 3, the Council sponsored a day-long judicial conference, divided into two sessions. The morning session—attended by MSNJ officers, executive secretaries of component societies, chairmen and members of judicial committees of component societies—centered upon the achievement of better understanding of, and increased efficiency in, the operation of the Society's statewide judicial mechanism. In the afternoon session, members of the MSNJ's Committee on Medical Defense and Insurance and chairmen of county medical review and advisory committees joined the morning group to discuss and distinguish the functions of the two in relation to each other. At this conference, the Council reemphasized the fact that the mechanism is concerned with, and limits its jurisdiction to, matters in the sphere of ethical conduct and professional deportment exclusively. All matters of law or allegations of violations of law are left to the courts.

COUNCILORS

Except for the summer interval, the Council meets monthly throughout the year. Its agenda is extensive. Its entire membership is regularly present. Attendance at these meetings necessitates one full Sunday a month. Thus I cannot close this report without recording the regret with which the Council has accepted the resignation of Dr. Isaac N. Patterson, Councilor for the Fifth District. Though his current term will not expire until 1965, Dr. Patterson finds it necessary to retire from the Council after 12 years of faithful and diligent service because of the pressure of other demands on his time. The constancy and conscientiousness which he brought to the Council these many years deserve special commendation and appreciation.

OPINION

Interpretation of Bylaws, Chapter VII, Section 9—Penalties:

"Every county Judicial Committee shall have the power to censure, suspend, or expel any member of its Society for just cause."

It is the unanimous opinion of the Judicial Council that the foregoing excerpt from the Bylaws of The Medical Society of New Jersey grants to Judicial Committees of component societies the power to "place on probation," since the designating of specific, broad penalties implies the right to impose a lesser penalty so long as the same is not inconsistent with those designated; and, because probation itself means allowing one to go about under a suspension of sentence during good behavior, or, in effect, to suspend the imposition of a graver sentence (i.e., suspension or expulsion).

Approved (page 325)

Standing Committees . . .

ANNUAL MEETING

Edward E. Seidmon, M.D., Chairman, Plainfield

(Reference Committee "H")

The Committee on Annual Meeting met in June of 1963 with the Scientific Program Committee and section officers to arrange the program for May 1964. A second meeting was held in the Executive Offices of The Medical Society of New Jersey on September 22, 1963, with the Scientific Exhibits Committee, the full Annual Meeting Committee, and representatives of all scientific sections present to finalize the full program for 1964.

The 1964 program for the annual meeting was arranged with great care. The section officers and the chairmen of the Committees on Scientific Exhibit and Scientific Program are to be commended on their fine cooperation. The program was arranged to allow for an all-inclusive program with selection of papers of wide interest to all segments of the medical profession. Again, this year, the program was specifically beamed toward the general practitioner and the papers and exhibits well correlated and integrated toward this end.

The informational, scientific, and technical exhibits total over 100. The scientific exhibits include the results of the latest medical investigations available in the past year. Members are urged to visit the exhibits and to take advantage of the latest information they present. The exhibits are an important educational part of the scientific sessions.

The 1964 program will include 62 scientific papers and a like number of speakers. Again, this year, through the cooperation of Smith Kline & French Laboratories, a motion picture program covering numerous scientific interests has been arranged. The committee wishes to express its appreciation to Smith Kline & French Laboratories for this valuable addition to the annual meeting.

In cooperation with the New Jersey Academy of Medicine and the New Jersey State Department of Health, a special program—including two papers in the morning session and two papers in the afternoon session—will be presented on Monday, May 18.

This year, the scientific program will be extended to 3:00 p.m. on Wednesday, May 20, instead of terminating at noon, allowing three days for the presentation of scientific papers. The scientific exhibits and the commercial exhibits will be open on May 18, and will extend to 3:00 p.m. on May 20.

By action of the Board of Trustees, the House of Delegates will convene on Saturday and Sunday, May 16 and 17, and Tuesday, May 19. Monday, May 18, will be an open day for the House of Delegates, so as to allow the members to visit the scientific sessions and the commercial exhibits.

The attendance during the 1963 annual meeting was 1,991; 1,018 were physicians. All component specialty societies were represented. Invitations to attend the annual meeting were extended to all New Jersey, Philadelphia, and New York City hospitals, as well as to the medical societies of Connecticut, Delaware, Maryland, New York, and Pennsylvania, with indication that there is no registration fee for out-of-state physician-guests.

Because of the heavy convention schedule in Atlantic City occurring each Spring, it is considered advisable to set the annual meeting dates at least four years in advance in order to assure desirable dates and hotel accommodations. The House of Delegates has already approved the following annual meeting dates which have been confirmed with Haddon Hall:

199th annual meeting — Saturday-Wednesday, May 15-19, 1965
200th annual meeting—Saturday-Wednesday, May 14-18, 1966
201st annual meeting — Saturday-Wednesday May 13-17, 1967

RECOMMENDATION

The Committee on the Annual Meeting recommends that the 202nd annual meeting be held at Haddon Hall, Atlantic City, Saturday-Wednesday, May 18-22, 1968.

Approved (page 335), with the recommendation that certain complaints be taken up with proper authorities of the hotel, for their attention.

*SCIENTIFIC EXHIBITS

Milton Ackerman, M.D., Chairman, Atlantic City

(Reference Committee "H")

The committee took the following actions during the year, 1963-1964:

1. Approved the proposed increase in charges for scientific exhibits and equipment by the official convention decorator—United Convention Decorators. The committee noted that the current rates had been in effect for over ten years.

2. Decided that the schedule for specific hours for "visits to exhibits" would be published in the regulations for exhibitors with the request that they are expected to be in attendance during these specific periods.

3. Recommended minor changes in the regulation governing location and type of identifying signs for exhibitors.

4. As per the recommendations of the Committee on the Annual Meeting, reduced the number of exhibit awards to three: a first-place plaque; a second-place plaque; and a single honorable mention certificate for third place, with all exhibits to be judged for awards in a single category only.

5. Accepted the offer of Smith Kline & French Laboratories to assume financial responsibility for the operation of the Motion Picture Theatre.

6. Reviewed applications for the scientific exhibit; selected and approved appropriate scientific exhibits; selected and scheduled appropriate films for the Motion Picture Theatre, and appointed a committee to review exhibits and designate awards.

Approved (page 335)

*SCIENTIFIC PROGRAM

Herschel S. Murphy, M.D., Chairman, Roselle

(Reference Committee "H")

A joint meeting of the Committee on Annual Meeting, the Subcommittee on Scientific Programs, and the section officers was held on June 23, 1963. Plans were discussed for the various section meetings and various joint section meetings.

On September 22, 1963, a second meeting was held, at which time the scientific program, with the names of the speakers and their subjects, was discussed more fully. With the joint programs agreed upon, we find that we will have twelve scientific sessions. There will be special discussions on Alcoholism, presented in cooperation with the New Jersey State Department of Health; Disaster Medical Care, presented by the scientific committee on this subject; Diabetes Mellitus, presented in cooperation with the Academy of Medicine of New Jersey; and a symposium on Carcinoma of the Stomach.

We feel that the scientific sessions will offer to our entire membership programs which will appeal to their special interests.

We wish to congratulate the section officers on their selection of topics and speakers. All members of our Society are urged to attend the sessions of interest to them.

Approved (page 335)

*Subcommittees of the Annual Meeting Committee.

CREDENTIALS

Marcus H. Greifinger, M.D., Chairman, Newark

(Reference Committee "A")

The Committee on Credentials throughout the year reviewed and acted upon membership applications and their supporting credentials as submitted through the component societies.

The committee again expresses appreciation to the officers of component societies for their cooperation.

The following statistical breakdown reflects the committee's activities during the period April 1, 1963 to April 1, 1964:

	Associate	Advancement to Active	Active	Total
Received	281	251	57	589
Reviewed and found:				
Satisfactory	242	235	46	523
Unsatisfactory	4*	0	0	4
Pending	35	16	11	62

*Do not hold degrees in medicine acceptable to this Society obtained from medical schools approved by this Society at the time of graduation.

Approved (page 325)

HONORARY MEMBERSHIP

F. Clyde Bowers, M.D., Chairman, Mendham

(Reference Committee "H")

On November 20, 1963, the Committee on Honorary Membership received a communication from the Board of Trustees of The Medical Society of New Jersey, in which the Board proposed Albert Bruce Sabin, M.D., for Honorary Membership in The Medical Society of New Jersey.

The Committee on Honorary Membership immediately conferred and carefully reviewed the candidate's qualifications. It noted especially his long residence in New Jersey as well as his many useful contributions to the science of medicine, with particular reference to his recent discovery of oral poliomyelitis vaccine. The committee unanimously concurred in the proposal of Doctor Sabin for Honorary Membership in The Medical Society of New Jersey and so notified the Board of Trustees on November 26, 1963.

Approved (page 335). Dr. Sabin was elected to Honorary Membership at the first session of the House (May 16, 1964).

Timely Tips to Prevent Drowning

For the thousands who will take to the water this summer, the Army Surgeon General's Office and the American Red Cross recommend the following to prevent drowning.

Lt. Col. Donald J. Strand, MC, Chief of the Environmental Hygiene Branch of The Surgeon General's Preventative Medicine Division, lists these safety precautions:

- Learn to swim or at least to float.
- Avoid swimming in unauthorized and unguarded areas.
- Always swim with a buddy.
- Do not dive into water of unknown depth.
- Know how to apply mouth-to-mouth resuscitation.
- Know the location and telephone number of your nearest water rescue or resuscitation agency. This is obtained from the nearest fire department or police station.

FINANCE AND BUDGET

Carl N. Ware, M.D., Chairman, Ocean City

(Reference Committee "B")

A review of the expenses of the first ten months of the current administrative year and an estimation of the expenses for the final two months indicate that the individual budget accounts are sound.

THE JOURNAL

In view of a decline in advertising of approximately 30 per cent through the State Medical Journal Advertising Bureau and the fact that the advertising rate increase of approximately 65 per cent did not become fully effective until March 1964, a deficit is anticipated again this year.

The anticipated deficit for publication of THE JOURNAL, editorial office expenses and travel, editor's insurance and salary taxes, assistant editor's salary taxes, contingent for extra help and other journal expenses will be charged off to the unexpended balance in the budget accounts at the end of the fiscal year. This will result in a small net deficit in the 1963-64 total budget.

Approved (page 326)

AMERICAN MEDICAL ASSOCIATION — EDUCATIONAL RESEARCH FOUNDATION

For 1964, the 1963 House of Delegates voted a per capita contribution of five dollars ($5.00) for AMA-ERF, in addition to, and not as part of, the budgetary assessment, with both to be paid at the same time.

For 1965, your committee recommends that the House of Delegates vote a special per capita assessment to serve as a contribution to the Medical Student Loan Fund (50 per cent), to the bicentennial fund (25 per cent), and to the Library of the Academy of Medicine of New Jersey (25 per cent). Your committee further recommends that the special per capita assessment apply equally to all dues-paying members, with no reduction for associate members as in the past, and that such special per capita assessment be levied in addition to, and not as part of, the budgetary assessment, with both being paid at the same time.

1965 ASSESSMENT

The computation of cash surplus at the close of the current fiscal year is estimated at $139,859.22—39% above the $100,000.00 sum which has been indicated as the desired surplus amount at the beginning of each new fiscal year.

The actual per capita requirement to meet the proposed 1964-65 budget is $44.68 per capita. By using $12,072.49 from surplus, the per capita assessment for 1965 can be retained at $40.00 per capita.

1964-65 BUDGET

The proposed budget for 1964-65 totals $258,-399.50. It is the opinion of the committee that the budget should adequately provide the necessary funds for the efficient operation of the Society's business during the coming year. It is not to be assumed that all sums budgeted will necessarily be utilized.

As requested by the House of Delegates, the committee is listing explanatory footnotes on accounts showing a marked difference between current and proposed budgets.

RECOMMENDATIONS

1. That the budget for 1964-65 be adopted in the total sum of $258,399.50.

Approved (page 326)

2. That the 1965 assessment be adopted at $40.00 per capita, with no provision for a contribution to AMA-ERF.

Adopted (page 326), with the recommendation that each man contribute to AMA-ERF according to the designation of his conscience to the school of his choice.

3. That if the House of Delegates votes a special per capita assessment to serve as a contribution to the Medical Student Loan Fund (50%), to the bicentennial fund (25%) and to the Library of the Academy of Medicine of New Jersey (25%), the special per capita level of contribution be set by the House in addition to and not as part of, the budgetary assessment, and that both be paid at the same time.

Approved (page 326), with a $5 per capita adopted for the year 1965.

ACCOUNT	Current 1963-64 Budget	Footnotes	Proposed 1964-65 Budget
A- 1 — Executive Salaries	$ 56,016.76	(1) (2) (3)	$ 56,528.73
B- — Journal Salaries	10,651.24	(2)	11,758.93
A- 2 — General Staff Salaries	52,039.09	(3) (4)	59,118.84
A- 3 — Executive Office Expenses	2,100.00	(5)	13,515.00
A- 4 — Executive Travel	2,425.00	(6)	2,760.00
A- 5 — House Maintenance	11,831.00	(7) (8) (9)	13,479.00
A- 6 — Treasurer	3,855.00		3,780.00
A- 7 — Finance & Budget Committee	100.00	(8)	85.00
A- 8 — Secretary	1,350.00	(8)	1,050.00
A- 9 — Salary Taxes	3,795.00		3,455.00
A-10 — Insurance	4,422.00*	(10)	4,629.00
A-11 — House Reserve	11,370.00	(7)	9,300.00
C- 2 — Legislative Council	6,200.00	(8)	4,700.00
C- 3 — Public Health Council	2,900.00	(8)	2,100.00
C- 4 — Public Relations Council	9,100.00	(8)	7,160.00
C- 5 — Medical Services Council	1,400.00	(8)	700.00
D- 1 — President and Presidential Officers	11,140.00	(8)	10,420.00
D- 2 — AMA Delegates	11,755.00	(12)	9,370.00
D- 3 — Woman's Auxiliary	3,350.00	(6) (8)	5,400.00
D- 4 — Medical Education Committee	325.00		135.00
D- 5 — Conference Groups	500.00		500.00
D- 6 — Credentials, Membership and Directory	3,150.00	(8) (11)	9,105.00
D- 7 — Disaster Medical Care Committee	200.00		150.00
D- 9 — Archives and History	100.00		100.00
D-10 — Blood Bank Commission	400.00		250.00
D-11 — Medical Defense & Insurance Comm.	350.00		300.00
E- 1 — Board of Trustees	6,000.00	(8)	4,750.00
E- 2 — Contingent	11,000.00	(8)	10,000.00
E- 3 — Judicial Council	900.00	(8)	500.00
E- 4 — Legal	8,300.00		8,300.00
E- 6 — Medical Student Loan Fund	5,000.00		5,000.00
Total	$242,025.09		$258,399.50

*$66.00 transferred from A-10 Insurance to Journal Expenses —Editor's Accident-Health Insurance Premium.

Approved (page 326)

FOOTNOTES

(1)—Increase due to salary increments to executive personnel authorized by the Board of Trustees.

(2)—Transfer of assigned personnel from A-1 to B, A-2 to A-1, and A-5 to A-2; to establish a separate salary account for Journal salaries.

(3)—Increase due to merited increments granted for selected personnel in certain job classifications.

(4)—3.7% Cost of Living adjustment with a rounding off factor to the nearest $5.00—abandonment of Cost of Living Formula effective 6/1/64—authorized by the Board of Trustees.

(5)—Establishment under Executive Office Expenses of three General items for Supplies and Services, Stationery and Postage, and Telephone, to which all such expenses will be charged except for specific project expenses, authorized by the Board of Trustees.

(6)—Increase due to AMA Meeting in San Francisco and AMA Clinical Meeting in Miami.

(7)—Difference due to transfer of one item from A-11 (House Reserve) to A-5 (House Maintenance).

(8)—Reduction due to transfer of funds from individual accounts to A-3 Executive Office Expenses (Footnote #5).

(9)—Increase in property tax and insurance rates.

(10)—Anticipated increase in insurance rates (of Hospital Service Plan of N. J.).

(11)—Increase due to publication of the 1964-65 edition of the Membership Directory.

(12)—Decrease due to the fact that the Delegation will operate its hospitality parlor at a level much less than that maintained in Atlantic City in 1963, when New Jersey was the host State.

MEDICAL DEFENSE AND INSURANCE

Daniel F. Featherston, M.D., Chairman, Asbury Park

(Reference Committee "D")

MAJOR MEDICAL EXPENSE INSURANCE

In the fall of 1963, our administrator, E. &. W. Blanksteen Agency, Inc., finished their enrollment canvass of the entire state society to achieve the required 50% quota so as to make it possible to issue major medical policies to impaired risk members and their impaired risk dependents. 2,785 members subscribed. Benefit payments in the early part of 1963 rose more rapidly than the premium volume. Rising costs of hospitalization, registered nurses and other covered expenses of the policy climbed upward very rapidly. When the September quarterly claim payment figures were available to the company it was realized that claim payments as well as administrative costs far exceeded the premiums being collected, and it was found necessary to increase the premium by 50% in an attempt to put major medical program on a more sound fiscal basis.

The increase of premium was approved by the Board of Trustees to go into effect as of March 1, 1964, the beginning of the current policy year.

Losses under major medical insurance can run to fantastic amounts in short periods of time. During the past year, three of our members collected the full maximum of $10,000, with 86 claimants collecting smaller but also sizeable amounts.

ACCIDENT AND HEALTH INSURANCE

During the past year, the E. & W. Blanksteen organization also successfully completed an enrollment for the Nationwide Mutual Insurance Company's additional plan of basic accident and health insurance in the balance of the state.

As of February 15, 1964, 2,967 members were insured under this program with policies being issued to the impaired risks in accordance with the enrollment rules. During the past year approximately $112,000 was paid by the Nationwide Mutual Insurance Company to 244 disabled claimants.

To complete the Nationwide Mutual Insurance Company's Disability Insurance part of our accident and health insurance program, E. & W. Blanksteen presented to us the extended coverage policy for this program, a policy similar to that of the extended coverage policy of the National Casualty Company. This was approved by the Board of Trustees on October 20, 1963. It is now possible for our members to buy up to $1,200 monthly basic disability insurance and $1,200 monthly extended coverage insurance—half in the National Casualty Company and half in the Nationwide Mutual Insurance Company.

Under the National Casualty Company's accident and health program which has been in effect since 1933, we presently have 3,905 members insured. Disability claims were paid by the National Casualty Company to 474 of our members during the past year for benefits in excess of $400,000, with the highest claim payment to one individual being $8,200.

HIGH LIMIT ACCIDENT POLICY

The high limit accident policy of the Nationwide Mutual Insurance Company through the E. & W. Blanksteen organization provides accidental death benefit and total disability coverage up to $200,000 for the member and up to $100,000 for the spouse. The plan is now in effect with 410 of our members. No claims have been presented as yet under this policy.

LIFE INSURANCE

There are presently 2,369—$10,000 Five Year Renewable and Convertible Term Life Policies in force on 1,842 of our members for a total volume of $23,690,000 of life insurance. During the past year, 18 death claims were presented and $170,000 has been paid in death claims—at this writing, one claim is pending.

Of the 18 death claims, 12 were impaired risks—risks who would not have been insured if it was *not* for the group type operation of the program which provided at the time of enrollment that impaired risks would be given $10,000 policies when the quota was achieved in the original enrollment.

Since the inauguration of the life program in March 1959, there have been a total of 70 death claims, out of which 53 were impaired risks at the time the policies were issued.

The life insurance program went into effect in 1959 and this year, 1964, is the end of the first five year period for many of our policyholder members. At the end of the five year period, the term policy is renewable for another five years for those who have not reached the 65th birthday, or it may be converted to a permanent form of insurance without medical examination—this is a built-in advantage of the program.

PROFESSIONAL LIABILITY

The American Mutual Liability Insurance Company has continued to improve the protection under the program by arranging for Defendant's reimbursement coverage as part of the policy. This provides for reimbursement to the insured doctor of $100.00 per day with a maximum for each lawsuit of $2,500.00. There is a deductable or waiting period of three days before this applies. Each day covered is one in which the insured defendant doctor spends three hours or more in depositions, trial preparation, or trial attendance. No other insurance company includes this coverage with a professional liability insurance policy.

For the past year, insurance protection for members of the medical profession was divided into four classes of practice. The membership has received information of this change which was intended more equitably to distribute the overall cost in direct relationship to the hazards and claim frequencies of the various types of practices and specialties.

During the year, following our agreement with the American Mutual Liability Insurance Company, we were forced to accept a premium increase aggregating 30% across the board as recommended by the American Board of Underwriters. We have received information that the figures submitted to the office of the Commissioner of Banking and Insurance in New Jersey, at the time the request was made for an increase, showed first, an expected loss and loss adjusted ratio of 54%, second an actual loss and loss adjustment ratio and figured at 1962 rates of 94%, third, the indicated change in rates applied for was 74.5% and fourth, the actual change by the Commissioner was 30%. This applied to all insurance companies controlled by the American Board of Underwriters.

Figures have also been supplied showing the yearly increase in rates since 1952 as they applied to New Jersey, based on National Underwriting figures. The reports submitted are in dollars of yearly premium:

TERRITORY I

	Physicians			Surgeons
9/1/52	35			53
5/24/54	60			90
9/1/57	60			105
10/31/60	60			144
3/1/62	78			187
	Class 1.	2.	3.	4.
5/31/63	84	105	202	280

TERRITORY II

	Physicians			Surgeons
9/1/52	20			30
5/24/54	35			53
9/1/57	35			61
10/31/60	35			84
3/1/62	46			110
	Class 1.	2.	3.	4.
5/31/63	50	63	120	165

As can be seen by the figures submitted on participation as of March 1, 1964, we have only improved our position over last year by 3%. We will face rather marked losses of the entire program if this figure is not improved. Most of the State has accepted the program willingly and the participation is excellent, but this undoubtedly contains a high percentage of members, who are denied professional liability coverages either by the previous carrier or other carriers; we therefore have in our 55% par-

ticipation of members a high percentage of bad risks. It has become almost a necessity to obtain participation from the members in areas which would improve the picture of the already enrolled group. Atlantic County continues to show 17% participation, Camden County 8%, Gloucester County 14%, Salem County 9%, Burlington County 18%, contrasted with figures for counties in other areas of the State, as high as 97, 94 and in the high 70's for other counties. Looking at incomplete figures of our three year record, we cannot hope to improve our premium rates unless we get as high as 75% participation on a state-wide basis. The one bright spot in the 1963 figures is the number of claims which were filed—175 against 282 filed in 1962. As for 1963, two cases were tried, both of which were won, the first by a directed verdict, the second by a Jury verdict of no cause of action. There are, however, some 129 suits filed, against which reserves must be maintained.

Effective May 1, 1964, the company is reducing its rates for limits of liability coverage in excess of $100,000 per claim and $300,000 aggregate (for all claims during the policy term). For instance, the cost for $500,000 per claim and $1,500,000 aggregate for a Class 4 specialist in the five northern counties was $862.00, and with this change the cost will be $700.00. For the Class 4 specialist in the other sixteen counties, this cost is reduced from $519.75 to $412.50.

PARTICIPATION AS OF 3/1/64

	Eligible	Insured	Percentage
Atlantic	167	27	17%
Bergen	740	493	67%
Burlington	132	24	18%
Camden	381	31	8%
Cape May	33	9	27%
Cumberland	100	49	49%
Essex	1,569	956	61%
Gloucester	77	11	14%
Hudson	607	294	48%
Hunterdon	49	46	94%
Mercer	434	150	34%
Middlesex	342	244	71%
Monmouth	354	248	70%
Morris	295	210	71%
Ocean	108	42	39%
Passaic	588	354	60%
Salem	44	4	9%
Somerset	106	99	93%
Sussex	38	37	97%
Union	619	388	63%
Warren	40	21	53%
TOTAL	6,823	3,737	55%

CLAIMS REPORTED TO 3/1/64 FOR POLICIES EXPIRING

	11-1-60	11-1-61	11-1-62	11-1-63	11-1-64	Doctors Insured as of 11-1-63
Atlantic	—	—	—	—	—	22
Bergen	1	10	27	16	10	493
Burlington	—	—	—	—	—	27
Camden	—	1	1	1	—	27
Cape May	—	—	—	—	—	8
Cumberland	—	—	1	2	—	48
Essex	2	40	67	47	5	964
Gloucester	—	—	—	—	—	10
Hudson	—	5	17	8	1	280
Hunterdon	—	—	1	2	—	44
Mercer	—	1	8	7	2	144
Middlesex	—	7	34	21	1	242
Monmouth	2	11	13	6	—	247
Morris	1	4	21	10	9	208
Ocean	—	3	12	4	—	40
Passaic	2	12	34	17	1	352
Salem	—	—	—	—	—	3
Somerset	—	1	8	14	—	97
Sussex	—	—	4	1	1	36
Union	1	11	34	18	3	386
Warren	—	—	—	1	—	22
TOTAL	9	106	282	175	33	3,700
REPORTED 3/1/63	9	75	209	35	—	—
DOCTOR INS. END OF EA. YR.	200	2,850	3,650	3,700	—	—

CLAIMS REPORTED TO 3/1/64 FOR POLICIES EXPIRING

	11-1-60	11-1-61	11-1-62	11-1-63	11-1-64	Doctors Insured as of 11-1-63
General practice—no major surgery	2	15	30	12	4	922
General practice—with major surgery	1	9	33	18	1	240
General Surgery	—	12	31	12	4	301
Internist	—	5	20	15	2	498
Cardiology	—	3	—	2	1	73
Gastro-enterology	—	2	3	1	—	34
Allergy	—	—	1	—	—	32
Pediatrics	1	4	14	10	1	270
Ob-Gynecology	1	12	33	24	10	262
Anesthesiology	—	10	34	24	3	197
Orthopedics	2	12	32	17	—	147
Radiology	—	1	7	6	—	97
Neurology-surgery	2	2	3	—	—	31
Psychiatry	—	2	2	1	—	93
Neuro-psychiatry	—	—	1	—	—	32
Ear, Eye, Nose, Throat	—	1	1	—	—	9
Ophthalmology	—	2	1	3	—	90
Otolaryngology	—	1	6	6	2	76
Pathology	—	2	—	1	2	67
Dermatology	—	2	9	4	1	51
Proctology	—	2	—	—	—	39
Urology	—	3	6	4	—	49
Plastic Surgery	—	2	4	3	—	18
Other	—	—	—	1	—	72
Premises Claims	—	2	11	11	2	
TOTAL	9	106	282	175	33	3,700

616 policies include premises coverage.

The chairman wishes to thank the committee for their attendance at our meetings and for their complete cooperation at all times—Doctors Fred Mettler, Ernest Hillman, Benjamin Slobodien, Elton Lance, William L. Palazzo—and to thank the Administrative Secretary, Mrs. Edith Madden, for her assistance.

RECOMMENDATIONS

1. That the E. & W. Blanksteen Agency be continued as the official brokers for our Major Medical Expense Insurance, Accident and Health, Life Insurance, and High Limit Accident Insurance Programs.

2. That the American Mutual Liability Insurance Company be continued as the officially designated carrier for our professional liability insurance program.

Approved as corrected (page 329), with commendation to the committee for making available such a wide choice of insurance to the members of MSNJ.

MEDICAL EDUCATION

Sherman Garrison, M.D., Chairman, Bridgeton

(Reference Committee "D")

A questionnaire was framed and submitted to New Jersey hospitals requesting information regarding their Interne-Resident problems. The following helpful suggestions were made. The number of Internes and Residents available in New Jersey could be increased by:

1. Increasing the number of medical school graduates by increasing the number of medical schools in New Jersey.

2. Decreasing the excess number of Internes and Residents in teaching hospitals associated with medical schools.

3. Increasing the number of foreign graduates in teaching institutions.

4. Increasing rotating affiliations between teaching hospitals and community hospitals.

5. Increased dissemination of information regarding vacancies in New Jersey hospitals.

6. Increasing medical school information and counselling on Community hospital opportunities for their graduates.

Approved (page 328)

More Residents could be attracted to individual hospitals by:

1. Improving teaching programs and requiring all qualified staff members to participate.

2. Increasing provisions for apartments and living quarters.

3. Improving the academic atmosphere in New Jersey hospitals by means of interested teachers, adequate library facilities, and—where possible—interesting research activities.

Approved (page 328)

The Medical Society of New Jersey may be of aid by:

1. Providing a central bureau for recruiting of Internes and Residents in New Jersey.

2. Negotiating with the ECFMG to provide more realistic tests and diminished language requirements.

The words "and diminished language requirements" were deleted (page 328).

3. Maintaining a list of areas of acute need throughout the State.

4. Encouraging the development and growth of medical schools in the State.

5. Considering the possibility of establishing throughout the State uniform remuneration for Internes, Residents, and House Officers.

The following recommendation of the reference committee was adopted by the House:

"6. That each interne, resident, and house officer have a councilor from the medical staff of his hospital."

Approved as amended (page 328)

Following these suggestions, the committee makes the following specific recommendations to the Board of Trustees:

1. The New Jersey delegates to the AMA should continue their efforts to diminish the number of Internes and Residents in teaching hospitals and propose a resolution to the AMA embodying the following points:

a. An effort should be made to decrease the number of Interneships presently held by graduates of American and Canadian schools in medical school hospitals so that such graduates will be available for community hospitals.

b. In filling their quotas, medical schools should be urged to accept a higher proportion of foreign graduates comparable to that of the present community hospitals.

Approved (page 328)

2. The Board should request the delegates to the AMA to ascertain if the Medical Education issue of the JAMA listing available Interneships and Residencies is now being forwarded to all acceptable foreign medical schools, and if not, to consider the advisability of this approach.

Approved (page 328)

3. The Board of Trustees is requested to designate a representative to discuss the possibility of further dissemination of information on available opportunities in New Jersey to foreign medical schools and the possibility of setting up a central bureau for recruiting Internes, Residents, and House Officers in New Jersey with **the consultative assistance of** Dr. Hilton Read and the Ventnor Foundation.

Amended to include the words "the consultative assistance of," as indicated.

Approved as amended (page 329)

4. The committee requests the Board of Trustees to invite the New Jersey Hospital Association to participate in joint discussions toward the standardization of remuneration for Internes, Residents and House Officers throughout the State.

Approved (page 329)

5. The committee recommends that an annual medical inventory of Interne and Resident personnel in each hospital in the State be made by The Medical Society of New Jersey in the fall of each year, specifically to determine the requirements of our hospitals in respect to Internes, Residents, and House Officers.

Approved (page 329)

The committee was requested by the Board of Trustees to investigate a request from the Academy of Medicine for library funds and recommendations favoring this support were submitted to the Board at its meeting on March 15. Action taken by the Board was referred to the 1964 House of Delegates for approval.

The committee is in the process of submitting questionnaires to Internes, Residents, and House Officers, which it is hoped will provide additional suggestions towards improving the Interne-Resident situation in New Jersey.

Approved as amended (page 329)

MEDICAL STUDENT LOAN FUND

Luke A. Mulligan, M.D., Chairman, Leonia

(Reference Committee "B")

As of April 1, 1964, the gross fund totals $171,-105.94—$163,633.94, General Fund; $6,042, Albert Barker Kump Memorial Grant; $1,430, Joseph E. Mott Memorial Grant.

In its seven years of operation, the Medical Student Loan Fund has granted a total of $120,325.35 in 126 loans to 89 New Jersey medical students. Five loans are being repaid by four recipients; one $1,000.00 loan has been fully repaid. To April 1, 1964, $4,250 has been repaid on principals, and $298.14 in interest.

Requests for financial assistance by New Jersey medical students are increasing each year; and if we are to continue our loan program, the Fund must have more money. For the 1964-65 school year, it is estimated we will have $20,-$22,000 available for loans which is $16,-$18,-000 short of the total amount of loans granted in 1963-64.

CONTRIBUTIONS

The committee is grateful to the many contributors to the Fund, and takes this occasion to acknowledge their support. A list of contributors to date (4/1/64) since the last report follows:

GENERAL FUND

Board of Trustees; County Societies: Burlington, Hudson, and Mercer.

State Auxiliary Executive Board, Fellowettes; County Auxiliaries: Atlantic, Bergen, Burlington, Camden, Cape May, Cumberland, Essex, Gloucester, Hudson, Middlesex, Monmouth, Ocean, Somerset, Union, and Warren.

Mr. and Mrs. Cornelius Alt, Miss Cherryl Androvbkis, Mr. and Mrs. Auerbach, Mrs. Catherine Appello, Mrs. Maude Blackburn, Mrs. Alice C. Bledsoe, Mrs. Robert G. Bloomer, Dr. and Mrs. Walter S. Booth, Dr. G. Victor Boyko, Mr. and Mrs. David D. Brown, Jr., Mrs. Ruth Brown, Dr. and Mrs. Ralph K. Bush, Dr. and Mrs. Henry D. Chieffo, Mrs. Barbara Clark, Elizabeth H. Clark, Mrs. Orlo H. Clark, Mr. and Mrs. Paul Clark and Son, Dr. and Mrs. Henry A. Connolly, Jr., Mr. and Mrs. Walter C. Crecco, Miss Anita V. Crocco, Dr. and Mrs. Millard Cryder, Dr. and Mrs. William E. Dodd, Mr. and Mrs. John Domesko, Mr. and Mrs. Joseph Douglas, Dr. and Mrs. S. Ellenson, Dr. and Mrs. J. Fabriele, Dr. and Mrs. Norman Flanzman, Mrs. Lewis C. Fritts, Mr. and Mrs. Gerald Gerry, Mrs. J. Howard Gould, Mr. and Mrs. N. Hanshee, Mr. and Mrs. M. Havala, Mrs. Elizabeth Hennessy and Family, Mr. and Mrs. Henry B. Henze, Mrs. Omar Hite, Mr. and Mrs. E. J. Hughes, Dr. and Mrs. Harold F. Hughes, Mr. and Mrs. A. Intoppa, Ivy Group Chiefs, Mr. and Mrs. J. Johnson, Mr. and Mrs. C. Kobleck, Dr. and Mrs. John F. Kustrup, Mrs. Hanna Larson, Mr. and Mrs. Jess Larson, Dr. and Mrs. A. Lepis, Dr. and Mrs. Samuel J. Lloyd, Vickie Lucatos, Mr. and Mrs. H. Lutz, Mr. and Mrs. G. H. Lynen, Elsie J. McCoy, Dr. and Mrs. Thomas H. McGlade, Dr. and Mrs. John R. Mabee, Dr. and Mrs. Benjamin Macchia, Mr. and Mrs. DeForest Main, Miss Pat Main, Mr. and Mrs. V. Melillo, Mrs. Helen Neil, Mr. and Mrs. John Pararas, Margaret Pemberton, Mr. Joseph Petrucelli, Mrs. Jennie Pistilli, Mr. and Mrs. John Pistilli, Mr. and Mrs. Nick Politis and Cathy, Mr. and Mrs. Z. Ponzarelli, Mr. and Mrs. Steven Poulos, Mr. and Mrs. J. Powell, Mr. and Mrs. Bernard Powlosky, Mr. and Mrs. Anthony Purcelli, Dr. and Mrs. Paul E. Rauschenbach, Dr. and Mrs. Carl J. Records, Ridgewood College Club Book Group, Dr. and Mrs. Joseph Rube, Mrs. Cora Ruoff, Mr. and Mrs. Anthony Santoro, Dr. and Mrs. John Scillieri, John and Walter Scott, Mr. and Mrs. S. Paul Shackleton, Mr. and Mrs. E. Stangis, Dr. and Mrs. John Stathakis, Mr. and Mrs. Peter Stathakis, Mr. and Mrs. Joseph Stepberger, Dr. and Mrs. Ciro Tarta, Mrs. Marie Tsucalas, Mr. and Mrs. J. Wesley Vanderclock, Mr. and Mrs. William Vanderclock, Dr. and Mrs. Bernard Venin, Mr. and Mrs. Emanuel Vidos, Mrs. Jacob Walder, Nicholas B. Walters, Eleanor H. J. Williams, Mr. and Mrs. Jack K. Williams.

IN MEMORY OF:

Edward N. Almgren, Helen Ruth Altman, Charles S. Ashby, Mrs. Atwood, Dr. E. J. Bacsik, Mrs. Barone, Dr. E. B. Beairsto, Douglas Beidel, Dr. Enoch Blackwell, Dr. James G. Boyes, Dr. George Brooks, Mrs. Chen, Mrs. Anna Christie, Dr. Robert J. Citrino, Mrs. Rose Elli, Mrs. James Farrant, Dr. Fred A. Finn, Alfonse Gaita, Paul L. Haeder, Mrs. A. S. Hanson, Mrs. Aloysius Hauck, Mr. Jehl, Dr. Julius Klosterman, Mrs. Kustrup, Louis Levin, Dr. George F. Liebrecht, Dr. Kenneth B. MacAlpine, J. C. McCarthy, Mrs. R. J. McDonald, Harry C. McKenzie, Dr. James J. O'Rourke, Mrs. Jennie Pettit, Mrs. Elizabeth Rhoades, Park Richards, III, Joyce Ricker, Dr. Eugene Robbins, Dr. William Schuchner, Mrs. Scielzo, Mrs. Alberta V. Small, Mrs. Hazel Steger, Mrs. Arthur L. Stone, Dr. Leslie Taber, Dr. James Tsucalas, Joseph Vlahovich, Dr. Robert B. Walker, and Dr. Edgar W. Weigel.

IN HONOR OF:

Mrs. Edgar W. Weigel.

RECOMMENDATIONS

1. That the House of Delegates appropriate monies to the Fund to be used for loans in 1964-65;

The House adopted a special $5 per capita assessment, 50% of which total will serve as a contribution to the Medical Student Loan Fund (page 326).

2. That the membership be urged to send contributions to the Fund; and

3. That the Woman's Auxiliary be requested to make the Fund its number one project next year.

DISTRIBUTION OF LOANS

County of Residence	*Medical School*	*Students*	*Loans Granted* 1957-1963	1963-1964
Atlantic	Hahnemann	1	$ 1,000.00	$
	Pittsburgh	1	1,000.00	1,000.00
	Seton Hall	1		1,000.00
Bergen	Hahnemann	1	1,000.00	1,000.00
	Seton Hall	5	2,000.00	1,000.00
	Woman's Medical	1	3,000.00	3,000.00
Burlington	Tufts	1	1,000.00	
	Duke	1	2,000.00	1,000.00
	Jefferson	1	2,000.00	
Camden	Jefferson	1	2,000.00	
	Michigan	1	2,000.00	
	Seton Hall	2	1,700.00	1,050.00*
	Temple	3	500.00	2,000.00
Cumberland	Jefferson	1	2,000.00	
Essex	Bern	1	2,325.35*	
	Duke	1		1,000.00
	Hahnemann	1		1,000.00
	Howard	1		300.00
	N. Y. Medical	1	1,000.00	
	Seton Hall	5	6,000.00	3,000.00
	St. Louis	1	500.00	
Gloucester	Temple	1	1,000.00	
	Albany	1		1,000.00
	Temple	1	2,000.00	
Hudson	Harvard	1	1,000.00	
	Howard	1	400.00	
	N. Y. Medical	1		1,000.00
	Seton Hall	14	10,800.00	6,000.00
	St. Louis	1	2,000.00	
Mercer	Hahnemann	2	3,000.00	
	Howard	1	1,000.00	
	Meharry	1	250.00	
	Mississippi	1	1,000.00	1,000.00
	Pennsylvania	1		1,000.00
	Seton Hall	3	5,000.00	1,000.00
	St. Louis	1	700.00	
Middlesex	Georgetown	1		500.00
	N. Y. Medical	1	2,000.00	
	Hahnemann	1		1,000.00
Monmouth	Columbia	1		1,000.00
	Jefferson	1		1,000.00
	N. Y. Medical	1		1,000.00
	Seton Hall	1	3,500.00	
	Temple	1	1,000.00	1,000.00
	Up-State N. Y.	1	1,000.00	
Morris	Dartmouth	1	1,000.00	
	Seton Hall	1	1,000.00	1,000.00
Passaic	Jefferson	1		1,000.00
	N. Y. Medical	1	1,000.00	
Somerset	Temple	1	3,000.00	
	Western Reserve	1	1,000.00	
Union	Hahnemann	1		1,000.00
	Seton Hall	10	8,800.00	2,000.00
15 Counties	23 Medical Schools	89	$82,475.35*	$37,850.00*
			($120,325.35*)	

(* Includes payments of insurance premiums.)

Approved (page 326), with commendation to the committee for its splendid record.

PUBLICATION

George B. Sharbaugh, M.D., Chairman, Trenton

(Reference Committee "B")

January 1964 heralded a new journal—from cover to cover, including cover. It was the first issue under our new printer, Hibbert Printing Company of Trenton. Also inaugurated with the new journal was its mailing by label. With the expanded and modern facilities of Hibbert, it is estimated that THE JOURNAL can save almost $1,800 a year by eliminating the wrapper. From the many congratulatory letters, we know you appreciate and like the change.

These are but a few of many changes authorized by the Board of Trustees during the past year in an effort to maintain our journal in a class second to none, and at the same time to economize as far as possible—in the face of the continuing decline of national pharmaceutical advertising. However, the bulk of the changes instituted as regards income and expenses is just now beginning to become operative. As of now, our total advertising income has increased substantially, and we expect this to increase even more.

JOURNAL CONTENT

From the tabular comparison of the last four years, you will see that THE JOURNAL has become a smaller book, in view of the loss of national advertising and a proportionate reduction in text material. It is hoped in this way to offset some of THE JOURNAL deficit.

	1960	1961	1962	1963
Book Reviews	25	33	28	21
County Society Reports	33	25	25	0
Editorials	30	34	36	28
Historical Material	11	6	0	0
Letters and Announcements	15	19	28	15
Original Articles	324	255	238	279
Psychosomatic Profiles			4	6
State Activities	280	240	263	209
Total of text material	718	612	622	558
Advertising	1124	844	781	620
Grand total of pages	1842	1456	1403	1178
Ratio: advertising/text	62%	56%	55.6%	53%

ADVERTISING

An overall increase in local advertising, classified advertising, and subscription and extra copies income is reported. However, national advertising continues to decline. According to the State Medical Journal Advertising Bureau, Inc. (the national bureau for state medical journals), net billing for the first quarter of 1964 is down about 22 per cent for the same period of 1963.

With the January 1964 issue, almost all advertising contracts were renewed at the increased rates. The committee recognizes that the major impact of these new rates will not be evident for at least six more months.

Effective June 1963, the Board engaged Mr. Joseph W. Cookson of Trenton as local (statewide) advertising representative. His efforts have brought an increase in local advertising.

The Publication Committee continues to work closely with the Board of Trustees, and has met in regular session three times since the last annual meeting. We hope you look upon THE JOURNAL as a valuable service, and as such give it your support.

STATEMENT OF INCOME AND EXPENSES

By action of the 1962 House of Delegates, the Publication Committee presents a financial statement, as part of its annual report. This will be supplied in a supplemental report to the House.

Approved, with commendation to the Publication Committee Chairman, Editor, Assistant Editor (page 326).

SUPPLEMENTAL REPORT

As directed by the 1962 House of Delegates, the Publication Committee presents this financial statement, covering the interval from June 1, 1963 through March 31, 1964.

Income	1962-63	1963-64
Advertising		
SMJAB	$26,741.77	$21,812.58
Local	8,324.57	9,196.89
Subscriptions and extra copies	443.83	1,004.46
SMJAB rebates	722.49	173.03
Total	$36,235.66	$32,186.96

Expenses		
(exclusive of salaries*)		
JOURNAL publication	$43,657.55	$39,748.65
Office expenses	522.14	770.69
Travel and committee expenses	392.24	302.18
Discounts and commissions		
SMJAB	4,257.59	880.19
Local	2,808.19	2,309.94
Bad debts	387.60	262.90
Total	$52,025.31	$44,274.55
Excess of expenses over income	$15,789.65	$12,087.59

The 1963 House of Delegates directed that the Editor's salary and a pro rata share of the Assistant Editor's salary (as determined by the Executive Director) should be charged against THE JOURNAL.

**Salaries*	
Editor (part-time)	$4,595.91
Assistant Editor (pro-rata share)	4,132.63
Total	$8,728.54

*Salaries provided for by general budget appropriation.

Approved (page 326)

REVISION OF CONSTITUTION AND BYLAWS

Louis F. Albright, M.D., Chairman, Spring Lake

(Reference Committee on Constitution and Bylaws)

A resolution from Burlington County—proposing a bylaw revision of Chapter XI, Section 4, paragraph (c), to increase the assessment of associate members from one-third (1/3) to two-thirds (2/3) of the "current per capita assessment"—was submitted to the committee for review. The committee reviewed the resolution and found it in proper form for submission to the House of Delegates.

Early in the year the committee reviewed and supplied several amendments to the "Model Constitution and Bylaws for Component Societies" which the Board of Trustees subsequently distributed for the information and guidance of all component societies.

The year now closing was a relatively light one as regards the work it called for from the committee, probably in consequence of the extensive revisions of the Constitution and Bylaws carried through in the recent past.

Adopted (page 324)

WOMAN'S AUXILIARY

George O. Rowohlt, M.D., Chairman, Dumont

(Reference Committee "H")

As in previous years, the official programs and projects of the Woman's Auxiliary for the year were submitted to and approved by the Board. The Advisory Committee wishes to thank and congratulate the officers and members of the Woman's Auxiliary for their cooperation with and supportive efforts to The Medical Society of New Jersey.

The work of the Auxiliary was so efficiently planned and consummated there was no need for a meeting of this committee.

The Auxiliary is to be especially commended this year for its outstanding effort in promoting a Safety Program for Senior Citizens. This is the first time our Woman's Auxiliary has made a concentrated effort in all counties on a particular phase of safety.

The committee is very happy to announce that Morris County is being organized at the present time. This is the realization of a long entertained hope. The Auxiliary to The Medical Society of New Jersey will now have twenty organized county units.

The Auxiliary has also been active in communicating the wishes of the Medical Society to our legislators, presenting a united front to protect the health and welfare of the people in this state.

Approved (page 336)

Administrative Councils . . .

LEGISLATION

Jesse McCall, M.D., Chairman, Newton

(Reference Committee "E")

Because some of the items dealt with here were acted upon by the 1963 Legislature and others are being dealt with in the 1964 session, we will of necessity deal with them separately.

1963 LEGISLATION

At noon on January 14, 1964, the 187th session (1963) of the New Jersey Legislature adjourned *sine die*. During that session a grand total of 1,235 pieces of legislation were introduced. The Council on Legislation gave detailed study to 128 measures as relevant to the Society's interest and concerns. During the session, the following were signed into Law (Public Laws of 1963) by the Governor. With the exception of S-103—concerning which the Society's position was one of no action—the position of MSNJ was approval.

S-57 —To provide that certain notices of hospital and medical liens may be filed in the county clerk's office within 90 days after the first day of treatment. (Chapter 99)

S-103—To provide that services performed by a duly registered bioanalytical laboratory are within the scope of medical service plans. (Chapter 158)

S-118—To authorize hospital service plan coverage of health care services by voluntary nonprofit visiting nurse organizations elsewhere than in a hospital. (Chapter 102)

S-173—To revise the provisions of law regulating the registration of physical therapists. (Chapter 169)

S-181—To require the licensing of blood banks and to regulate their operation. (Chapter 33)

A-62 —To exempt licensed medical practitioners from civil action arising out of emergency care at the scene of an accident. (Chapter 140)

A-193—To provide that data in possession of the State Department of Health pertaining to the health of any named person, procured in connection with research studies, approved by the Public Health Council for the purpose of reducing the morbidity or mortality from any cause or condition of health, shall be kept in confidence by the Department except to persons participating in research study or in such impersonal form that the individual concerned cannot be identified. (Chapter 68)

A-243—To grant certain exemptions from specific requirements for physicians licenses to M.D.'s on the staff of a state or county agency. (Chapter 30)

A-547—To provide for the willing of eyes for the purposes of transplanting to other human beings. (Chapter 154)

1964 LEGISLATION

Since the opening of the 1964 State Legislative Session in the afternoon of January 14, the council has considered the following bills, on the basis of detailed analyses supplied by its Legislative Analyst. All measures thus marked (*) are identical with bills of 1963 or preceding years, and the official position of The Medical Society of New Jersey concerning them remains the same. For the information of the House, the council reviews its regular range of positions:

Active Support . . . all-out support for the measure;

Active Opposition . . . all-out opposition for the measure;

Approval . . . commended as satisfactory, but not actively supported;

Disapproval . . . rejected as unsatisfactory, but not actively opposed;

No Action . . . considered, but not regarded as significant or relevant to the proper interests of the Society.

(Positions of active opposition and disapproval are always accompanied by a statement of reasons.)

S-1 —Permits a dentist to receive payments for claims, under a medical service plan, for services performed in an approved hospital. *Approval*

*S-21 —Prescribes a mandatory sentence of im-
*A-141—prisonment at hard labor for 20 years to life for persons who hire, use or employ a child under 18 to transport, carry, sell, prepare for sale or offer for sale morphine, cocaine, heroin, opium or any derivative, or marihuana, for any illegal purpose. *No Action*

*S-22 —Increases the penalties for narcotic drug
*A-139—conviction as follows: sale, gift or administration to a person under 18, imprisonment at hard labor for 20 years to life; illegal

sale or manufacture, fine of $2,000 and 10-20 years sentence for the first offense, $5,000 and 20-30 years for second offense, and $5,000 and 30 years to life for third and subsequent offenses; provides that no sentence shall be suspended. *No Action*

*S-23 —Provides that sentence may not be suspended after conviction of, or plea of guilty or non vult to, criminal violations involving the manufacture or sale of narcotic drugs. *No Action*

S-41 —Revises and supplements the Workmen's Compensation Act relative to the Second Injury Fund by increasing its size from $1,500,000 to $3,000,000 and provides a new formula for determination of employers' liability for subsequent disabling injuries other than total permanent disability. *Approval*

S-45 —Prohibits any person from operating a motor vehicle while having in his possession or in the motor vehicle any narcotic drug; prescribes penalties for violation. *Approval*

*S-65 —Requires all passenger cars manufactured
*A-266—after July 1, 1964, and registered in this State, to be equipped with at least 2 sets of seat safety belts for the front seat. *Approval*

*S-71 —Provides that any condition or impairment
*A-69 —of health to a uniformed member of a paid or part-paid fire or police department, caused by any disease of the respiratory system resulting in total or partial disability, shall be deemed to be an occupational disease. *Disapproval* . . . because they involve diagnosis by legislative enactment rather than by medical investigation.

*S-72 —Provides that any condition or impairment
*A-8 —of health caused by a disease of the respiratory system resulting in total or partial disability to a uniformed member of a paid fire or police department, who successfully passed a physical examination on entry into such service, shall be presumed to be an injury received in the performance of duty. *Disapproval* . . . because they involve diagnosis by legislative enactment rather than by medical investigation.

S-73 —Provides that any condition or impairment of health caused by a disease of the respiratory system resulting in total or partial disability to a uniformed member of a paid fire or police department, who successfully passed a physical examination on entry into such service, shall be presumed to be an injury received in the performance of duty. (Companion bill to S-72 and A-8, reported above.) *Disapproval* . . . because it involves diagnosis by legislative enactment rather than by medical investigation.

S-74 —Permits county freeholders to appropriate funds to any approved, private, nonprofit, nonsectarian organizations for the diagnosis, treatment and training of mentally ill or retarded county residents. *Approval*

*S-85 —Requires every action at law by the parent or guardian of a person under the age of 21 years for damage derived by reason of an injury to such person caused by the wrongful act, neglect or default of any person to be commenced by the parent within the same period of time as is provided by law in the case of the person so injured. *Approval*

*S-89 —Provides that 9 bipartisan public trustees of a hospital service corporation shall be appointed, 3 by the Governor, 3 by the President of the Senate, 3 by the Speaker of the General Assembly, 1 of each group to represent a labor organization and 2 representatives of the general public; provides that not more than 16 of the 32 trustees shall be employees, directors, or trustees of hospitals, members of the medical profession or employees of a hospital or medical service corporation. *Disapproval* . . . in support of the position of opposition of the New Jersey Hospital Association.

S-90 —Provides for the approval, inspection and regulation of rest homes for the sheltered care of adult persons. *Approval*

*S-92 —Defines, and provides for the regulation of, boarding homes for sheltered care; amends the laws regulating convalescent homes, private nursing homes, and private hospitals. *Approval*

S-93 —Amends the law concerning hospital service corporations. *Approval*

S-94 —Amends the law concerning medical service corporations. *Approval*

*S-120—Defines "nonpoisonous patent or proprietary medicines," which may be sold as packaged medicines by general merchants. *Disapproval* . . . because the council is of the opinion that Section 2 of the measure empowers the manufacturer to determine what is non-poisonous. This section declares: ". . . the term 'non-poisonous' shall mean and include those preparations which are not dangerous to health when used in the dosage, or with the frequency or duration prescribed, recommended, or suggested in the labeling thereof." The council considers that it is unwise and undesirable and contrary to the public interest that the manufacturer be the sole arbiter of what is "non-poisonous." Moreover, MSNJ looks with disfavor on any legislation which would relax the salutary controls necessary for the protection of the public and which would tend to encourage self-medication on the part of the public.

*S-148—Provides that disability occurring to a member of a voluntary fire department, caused by respiratory disease or tuberculosis, shall be deemed an occupational disease, if manifested while such person is an active member. *Disapproval* . . . because it involves diagnosis by legislative enactment rather than by medical investigation.

S-164—To provide that physicians once admitted to practice on the medical staff of a hospital, infirmary, dispensary or clinic may not be denied such privilege without just cause or without a hearing. *Approval*

*S-181—To authorize charges for diagnostic services and treatment at county mental centers or institutions. *Approval*

*S-182—To permit county hospitals to accept private patients who cannot obtain admission within a reasonable time to a voluntary hospital in a county. *No Action*

*A-1 —Revises the statutes concerning the practice of pharmacy and the regulation and control of the sale and distribution of drugs, medicines and poisons. *Approval*

*A-19 —Permits commercially written hospitalization and medical-surgical insurance to be written

for senior citizens at reasonable rates. *Approval*

*A-26 —Amends the Workmen's Compensation law to provide that temporary and total permanent disability benefits be paid at the rate of 66-2/3% of weekly wages with a maximum of 66-2/3% of the annual average weekly wage in covered employment and minimum benefits of $15 per week, partial permanent disability benefits to be paid at the rate of 66-2/3% of wages with maximum of 50% of the annual average weekly wage covered employment and minimum of 15 per week; increases the full compensation period for widows from 350 to 450 weeks; increases dependent allowances; establishes an Uninsured Employers' Fund and a Board of Appeals; effective January 1, 1965. *Disapproval* . . . in consistency with the declared position of MSNJ in support of free choice of physician.

A-42 —Provides that any person who uses, or is under the influence of or who possesses, or has under his control, amphetamine, barbiturate, barbital, hypnotic or somnifacient drugs, tranquilizers or any prescription legend drug, in any form, unless obtained from, or on a valid prescription, is a disorderly person. *No Action*

*A-92 —Revises generally the statutes dealing with the registration of vital statistics. *No Action*

*A-111—Proposes a general revision of the laws governing mental health, designated as "The Mental Health Act of 1964;" effective January 1, 1965. *Approval*

*A-112—Amends the law governing persons confined to institutions by court order, and requires persons admitted to the State Sanatorium for convalescence from tuberculosis or respiratory disease be liable for care costs in the same manner and extent as required from mentally ill or retarded persons or relatives; effective January 1, 1965. *Approval*

*A-113—Permits a court hearing a mental competency proceeding to order a trial by jury; extends the jurisdiction of county courts and the Superior Court to make determinations; permits a guardian to be appointed for the person or his property, or both; effective January 1, 1965. *Approval*

*A-114—Permits an injured employee under Workmen's Compensation Act to select any licensed physician for treatment, without notice to employer; requires employers provide necessary medical care in emergencies and when notified in writing that employee does not desire to select a physician. *Approval*

*A-129—Authorizes the Commissioner of Banking and Insurance to disapprove and determine the rate of payment to a participating physician under a medical service corporation or medical service plan. *Active Opposition* . . . because it would empower the Commissioner of Banking and Insurance to fix fees to be paid by MSP to participating physicians and would therefore constitute an unwarranted and unjustifiable denial of the fundamental right of the physician to set his own fee for professional services rendered, thus threatening the operation of the Plan, in disregard of the best interests of the approximately two million people of New Jersey who are its subscribers.

*A-140—Designates it a misdemeanor for any person, other than a pharmacist, to sell any preparation or mixture or compound of drugs containing codeine or any barbiturate to any person under 21 years of age, without a written prescription of a physician, dentist or veterinarian. *Disapproval* . . . until recommendations for broadening the prohibition are included.

*A-142—Provides that sentence may not be suspended after conviction of, or plea of guilty or non vult to, criminal violations involving manufacture or sale of narcotic drugs. *No Action*

*A-150—Permits wage assignments by nonprofit corporations conducting hospitals for the care and treatment of patients, for the payment of the cost of such care and treatment. *No Action*

*A-153—Prohibits as a disorderly person offense the discharging of certain matter or material into the inland tidal waters of the State or operating a vessel that contains toilet facilities not equipped with an operating chlorinator or other sewerage disposal system meeting the requirements of the State Department of Health; provides that the owner of the vessel shall be responsible for violations on his vessel. *Approval*

*A-162—Requires every person engaged or employed to drive school buses to undergo periodic medical examination to determine his mental and physical condition to safely operate such vehicle. *Approval*

*A-169—Provides that no insurance company, corporation or hospital or medical service corporation shall be entitled to be subrogated by contract to any claim of the insured as against any third party for damages for hospital or medical services as to any hospital or physician's lien by reason of payment to the insured or any sum of money for his hospital or medical services; effective January 1, 1965. *Disapproval* . . . because the Socicty is on record approving the opposite principle, as contained in S-4 of 1963.

A-200—Prohibits as a disorderly person offense, the selling, offering for sale, buying, exchanging, possessing or giving away of any fire extinguisher containing a carbon tetrachloride; specifies a fine of not more than $100 or imprisonment for not more than 60 days or both; effective January 1, 1965. *No Action*

*A-216—Provides that any person who shall hypnotize or attempt to hypnotize another person for purposes of entertainment is a disorderly person. *Approval*

A-221—Provides that any civilian voter who claims the right to vote by absentee ballot by reason of temporary disability shall complete the required certificate but need not supply a physician's certificate. *Disapproval* . . . because it would encourage self-diagnosis.

*A-228—Provides for the registering of dental laboratory operators and assistants by the State Board of Registration and Examination in Dentistry. *Disapproval* . . . in support of the position of the New Jersey State Dental Society, which contends that the bill is loosely drawn.

*A-231—Defincs "non-poisonous patent or proprietary medicines" as packaged drugs and

medicines which are sold to the general public under a trademark, trade name, or other trade symbol privately owned and properly labeled whether or not registered in the United States Patent Office. *Disapproval . . .* because it would encourage self-medication.

*A-258—Requires an application for a permit to carry a firearm to have attached a report of a duly licensed physician, on a form to be prescribed by the Superintendent of State Police, setting forth the applicant's condition, both mental and physical. *Disapproval, with active opposition if bill moves . . .* because it would impose upon the physician a responsibility of determination which could be only supported by an extensive and detailed series of tests and examinations, and because it also would expose the physician unnecessarily to liability.

*A-261—Requires a prescription for a narcotic be on a special narcotic prescription form of a type and design established by the Department of Health; requires prescription to be retained in a separate file. *Disapproval . . .* because it is unnecessary and unrealistic, and places a burden on the general public to protect itself against forgers and counterfeiters.

*A-312—Repeals the law requiring migrant laborers to show evidence of 90-day examination for venereal diseases, or to submit to examination. *Disapproval . . .* because it regards the present law as salutary and desirable for the effective control of venereal disease among migrant workers.

A-362—Permits any county, municipality or school district employee to form a group for the purpose of obtaining major medical insurance. *No Action.*

*A-418—To extend the time for filing petitions under the Workmen's Compensation Act in cases of exposure to ionizing radiation. *Approval.*

*A-447—To amend the provisions of the welfare laws dealing with assistance for the blind to make certain changes concerning the eligibility for care in certain medical institutions. *Approval*

*A-474—To regulate and license the collection and disposal of solid waste to create a Division of Refuse Control in the State Department of Health and an advisory council to said division. *Disapproval . . .* in support of the position of the Health Department that the legislation is unnecessary and undesirable.

*A-511—To require the use of humane methods in the slaughter of livestock. *No Action*

A-514—To provide for mandatory reports by physicians or hospitals to the county prosecutor of cases involving serious physical injury, other than by accidental means, inflicted on children by person having custody of them. *Approval*

MEDICAL TECHNICIANS

Despite all the Society's efforts, the 1963 legislative year brought us no closer to enactment of an amendment to the Medical Practice Act that would extend legal protection to medical and x-ray technicians acting at the direction of a licensed physician (S-138 of 1963). In October 1963, representatives of MSNJ met with a representative of the Governor's legal staff in an effort to achieve passage of this measure. Discussion at the meeting centered chiefly about the meaning of the term "medical technicians." In March 1964, the Governor reported that "there are substantial differences of opinion through the several interested departments of State in regard to such legislation." He and the Attorney General have grave concern over proposals of the bill which would "seemingly authorize any individuals to perform any medical functions without limitation, so long as he is under the supervision of a licensed physician." The Governor called particular attention to his veto statement of S-199 (1963), issued in March 1964. While this bill concerned itself with the practice of chiropractic, the fundamental concern of this legislation—to legalize the utilization of ancillary technical personnel—is practically identical with that of S-138. It is the Governor's opinion that any future legislative consideration of a bill on this subject should be attended by a "serious and thoroughgoing study and delineation of the exact nature of the services involved, and the probable impact of such a law upon the health and safety of those who require treatment."

Thus the council is confronted with the necessity of specifying, in terms acceptable to all concerned, what exactly would be the qualifications and the approved activities of each type of medical technician to be covered. Once acceptable definitions have been agreed upon, or some other feasible solution arrived at, the council will again evolve an appropriate amendment and proceed to re-introduce the legislation.

OPHTHALMIC TECHNICIANS

At the request of the 1963 House, the council considered a resolution (#17) requesting MSNJ to "take whatever restrictive measures are necessary to combat this attempt to cur-

tail and restrict the traditional right of physicians to utilize the services of assistants as they see fit for the proper practice of medicine in New Jersey." The council agreed with the Legislative Analyst that the premise upon which this resolution was based is false, since, by law, a physician may utilize only those persons to assist him in the practice of medicine who are licensed under the Medical Practice Act (R.S. 45:9-21, paragraph k).

The council also agreed that its proposed amendment to the Medical Practice Act concerning medical and x-ray technicians, if adopted, will take care of the subject of this resolution.

UNION FAMILY HEALTH GROUPS

The council received the 1963 House report which directed that a copy of a resolution (#5) concerning union family health groups which have recently been organized by unions, industries, hospitals, and other non-medical groups for the practice of medicine be brought to the council's attention "so that it may be alerted to the problem."

In conjunction with this resolution, the council requested that the Bergen County Medical Society (sponsors of the resolution), or any other county society, keep the council informed of further developments in the matter.

SCHOOL EXAMINATION LAW

Since 1957 the council has introduced from time to time, and supported for passage, legislation to revise that section of the law which would authorize a school medical inspector to accept evidence of a satisfactorily performed physical examination in lieu of the required school examination. Recalling its decision (approved by the Board) to exert pressure for enactment of legislation concerning medical technicians, the council cannot re-introduce the school examination law until such time as positive action is taken on a medical technicians' bill. The council will continue its efforts in this regard, however, and will attempt to re-introduce this legislation at the earliest practicable time.

REPORTING OF EPILEPSY BY PHYSICIANS

At the request of the 1963 House, the council has studied the New Jersey Law, R.S. 26:5-1, requiring the reporting of epilepsy by physicians. This matter is—and has been—under consideration by representatives of the Medical Society, the State Department of Institutions and Agencies, the State Department of Law and Public Safety, the Division of Motor Vehicles, and the New Jersey State Department of Health. In this conjunction, there has recently been an encouraging development in the form of an opinion supplied by the office of the Attorney General. In substance, that opinion points out that only the physician who is "in charge of a case of epilepsy"—that is, who is actually treating the patient for epilepsy as such—is obligated to report under the requirements of R.S. 26:5-1. This opinion is reflected in detail in the report of the Special Committee on Traffic Safety, to which report the members of the House are referred for their further enlightenment. Suffice it to say that steps already taken seem to be leading to the clearing up of this hitherto confused situation and afford a basis for the hope that in the near future the matter will be satisfactorily and fairly resolved.

STATEWIDE MEDICAL EXAMINERS SYSTEM

At the request of the 1963 House, the council has been participating in discussions relating to improvement of the present system of investigating unusual deaths. Preliminary meetings have been held, and other meetings are being arranged. The council will continue in its efforts to bring the matter to resolution and will keep the members informed of its progress.

NATIONAL LEGISLATION

In January 1964, at the request of the council, the Board of Trustees directed the President to call upon all members of The Medical So-

ciety of New Jersey and its Woman's Auxiliary to take part in a nationwide campaign of letter-writing to members of the United States House of Representatives, to urge them to do all in their power to oppose the enactment of HR 3920 (King-Anderson, 88th Congress), presently in the House Committee on Ways and Means. The council takes this occasion to remind the members that they must continue their efforts—as citizens and as physicians—to make it clear that the position of New Jersey voters is overwhelmingly against this type of legislation. HR 3920 would extend social security coverage to make available limited hospital and nursing home services to all persons over the age of 65, whether they are financially able to pay for their own health care or not.

An excellent and comprehensive statement of our opposition to HR 3920 was read into testimony by the House Ways and Means Committee last November. It was submitted by President Kaufman who, with our Executive Director, has led and stimulated the Society's activities.

Further activity in connection with this and related measures will be determined by subsequent developments in Washington.

* * *

Because the Council on Legislation is scheduled to meet at the end of April, a supplementary report will be submitted to bring the House up to date on current state legislation. Meanwhile, the council will continue to follow the Legislature, to review referrals from the Board of Trustees, and to screen bills that come before it.

Approved (page 330)

SUPPLEMENTAL REPORT

Since preparation of the annual report of the Council on Legislation, distributed in advance to the House of Delegates, it has been necessary for the council to hold another meeting in order to supply recommendations concerning state legislation recently introduced.

To bring the House up to date concerning the legislation thus dealt with and concerning the Society's positions as approved by the Board of Trustees, the council respectfully presents this supplemental report.

S-171—Permits bioanalytical laboratory testing only by laboratories registered in New Jersey. *No Action*

*S-199—Provides that each offense involving sale or dispensing of narcotics by a person over 21 to a person under 18, after a third offense, shall be punishable by a fine up to $5,000 and 10 years to life imprisonment at hard labor. *No Action*

S-202—Defines as the practice of optometry, subject to regulation, the offering and marketing for retail sale of spectacles or eyeglasses other than plano lenses; exempts a duly licensed ophthalmic dispenser providing spectacles or eyeglasses upon the prescription of an optometrist or physician. *No Action*

S-210—Establishes a Narcotics Advisory Council in the Department of Institutions and Agencies to study, promote, and effectuate a comprehensive plan for the prevention and control of drug addiction, diagnosis, treatment and control of addicts; repeals P.L. 1953, Chapter 449, creating a permanent commission on narcotic control. *No Action*

S-215—Provides for the continued hospital, surgical, medical, and major medical coverage of retired members of the Public Employee's Retirement System. *Approval*

S-235—Amends the law to designate the employment of a child under 18 to transport or sell narcotics as a high misdemeanor. *Approval*

S-236—Amends the law to designate the sale of narcotics by a person over 21 as a high misdemeanor when the sale is for pecuniary gain and tending to corrupt youth. *Approval*

S-237—Prohibits the suspension of a sentence of 20 years at hard labor which is required for a narcotics crime conviction as described in S-236, 1964. *Approval*

*S-249—Permits the licensing of professional nurses
*A-595—at age 18, instead of 20. *Approval*

S-265—Provides that any person convicted as a disorderly person for being under the influence of any narcotic drug not prescribed as treatment for sickness or injury shall forfeit his right to drive for a period of 1 year in addition to the penalty for disorderly conduct. *No Action*

S-276—Clarifies the laws permitting counties, municipalities, school districts, and other public agencies to provide group insurance and hospital and medical services for their officials and employees. *Approval*

*S-282—Amends the Workmen's Compensation law broadly, including provision for maintenance by employers of a panel of physicians to treat injured employees. *Disapproval . . .* in consistency with the declared position of MSNJ in support of free choice of physician.

S-314—Extends provisions of the State Employees
A-676—Health Benefit Act to teachers and other local employee groups; effective July 1, 1964; designated the "Public and School Employees Health Benefits Act." *Approval*

S-315—Creates a 3-member State Board of Chiropractic to supervise and license the practice of chiropractic. *Disapproval* . . . because the public interest is better served by retaining licensure under the control of the State Board of Medical Examiners.

A-218—Regulates the practice of removing superfluous hair from the body through registration and licensing of electrologists by the Board of Medical Examiners. *Disapproval* . . . because it would give electrologists freedom to perform, at their own discretion, procedures which could be inimical to the health and welfare of their patients.

*A-315—Provides that any person who sells any narcotic drug to any person under the age of 21 instead of 18 shall be punished by imprisonment at hard labor for not less than 10 years and no such sentence shall be suspended. *No Action* . . . in view of approval of a higher penalty.

*A-360—Revises the statutes pertaining to production, handling, and distribution of milk, cream, and milk products. *Approval*

A-412—Provides that a person's refusal to the taking of a breath specimen shall justify an inference that an analysis of such specimen would show the presence of an illegal percentage of alcohol in the blood. *Approval.*

*A-423—Proposes extensive changes in the rules, regulations, and standards required in licensing of boarding and rest homes. *Approval*

*A-430—Amends the act governing the licensing and regulating of private nursing homes and private hospitals. Provides that "No license shall be granted to a hospital facility unless the Commissioner (Institutions and Agencies) is satisfied that it is adequately prepared to provide all services and care required by the residents of the community wherein it is located." *Disapproval* . . . because the bill is unclear and confers a hazardous grant of power to the Commissioner that could be incompatible with the public interest.

A-520—Requires the testing of newborn children for purposes of the early detection of pheylketonuria (PKU); appropriates $100,000; effective January 1, 1965. *Referred to Special Committee on Maternal and Infant Welfare*

A-559—Permits any county or municipality to establish and maintain a narcotic treatment center. *Approval*

A-568—Provides that if a second conviction of drunken driving occurs 10 or more years after the previous conviction, the court may suspend the jail sentence and impose a fine of not less than $300 or more than $1,000 and place the person on probation; effective on the 91st day after enactment. *No Action*

A-583—Requires places of employment, including
A-626—newspapers, to be constructed, operated, and maintained with reasonable regard to the health and safety of the employees; designated the "Worker Health and Safety Act." *No Action*

A-587—Requires every pupil to be immunized against polio. *Approval*

A-642—Regulates the manufacture, sale and distribution of frozen desserts and special frozen dietary foods; provides for the inspection, sanitation and licensing of frozen dessert plants; provides for the promulgation of standards of identity and definition of frozen desserts and special frozen dietary foods; effective January 1, 1965. *Approval*

A-644—Provides that any person who has served as a sanitary inspector first class in any municipality for a period of 10 years and as executive officer of a municipal board of health for at least 10 years, shall be entitled to obtain a license as a health officer without taking an examination. *Disapproval* . . . because it is special legislation, discriminating against the public interest in favor of an individual.

Approved (page 330)

Scientific Exhibit Awards

The Committee on Awards of the 1964 Annual Meeting of The Medical Society of New Jersey, Atlantic City, May 16-20, announces the following selections:

First Place—Scientific Exhibit of individual investigation, judged on the basis of originality and excellence of presentation.

S-219—*An Arterial Graft of Biologic Origin*
Norman Rosenberg, M.D., John Henderson, M.D., Geoffrey H. Lord, D.V.M., James W. Bothwell, Ph.D., Eugene R. L. Gaughran, Ph.D., Middlesex General Hospital, The Johnson & Johnson Research Foundation, New Brunswick

Second Place—Scientific Exhibit of individual investigation, judged on the basis of originality and excellence of presentation.

S-206—*Gastroscopy*
Francis X. Keeley, M.D., Robert L. Breckenridge, M.D., Our Lady of Lourdes Hospital, Camden

Honorable Mention Certificates

S-225—*Repair of Ventricular Septal Defects Via the Atrium*
Robert S. Litwak, M.D., Howard L. Gadboys, M.D., Ralph Lev, M.D., The Mount Sinai Hospital, New York, New York

S-227—*A New Industrial Disease—Chloracne With Porphyria Cutanea Tarda*
Roger H. Brodkin, M.D., Jacob Bleiberg, M.D., Newark Beth Israel Hospital

MEDICAL SERVICES

Irving Klompus, M.D., Chairman, Bound Brook

(Reference Committee "F")

ACCREDITATION OF NURSING HOMES

The council requested the AMA and the Joint Commission on the Accreditation of Hospitals to explain the withdrawal of plans for the accreditation of nursing homes and other facilities for the care of the long-term ill. This action was taken in consequence of a referral to the council from the Board of Trustees. The replies from the AMA and the Commission revealed that the American Nursing Home Association elected not to participate in the project, and a stalemate was reached where, if a national accreditation program were to be inaugurated, it would be done without the support of the largest single organization within the nursing home field. In view of this, the AMA felt that such a move on the part of the Joint Commission would be most unsatisfactory and therefore opposed the creation of a division of accreditation for inpatient care institutions other than hospitals. Recognizing the need for a national accreditation program for nursing homes, the AMA then opened negotiations with the ANHA jointly to sponsor a national accreditation program. This move on the part of the AMA met with the approval of the ANHA, and plans progressed to develop such an organization. Accreditation standards were developed, and the National Council for the Accreditation of Nursing Homes began its accreditation program in August 1963.

The council accepted these replies as satisfactory for the purposes of Resolution #8 (1963), which was the basis of the original referral from the Board of Trustees.

Received as progress report (page 332)

UTILIZATION OF HOSPITAL BEDS

On referral from the Board of Trustees in furtherance of the wishes of the 1963 House of Delegates, the council studied the question of utilization of hospital beds. As of January 1964 —as the result of a survey covering short-term hospitals of New Jersey, made by the New Jersey Hospital Association—there were 80 hospitals that have admission and discharge committees and 12 that do not. Osteopathic hospitals are not reflected in these figures. Further study is being made, and efforts will be made to achieve the establishment and maintenance of such committees in the hospitals that lack them.

Received as progress report (page 332)

ANESTHESIOLOGIST PARTICIPATION IN MSP

The council studied the question of anesthesiologist participation in the Medical-Surgical Plan. The analysis of membership participation in the medical and surgical plan has taken considerably longer than expected, and progress only is reported.

Received as progress report (page 332)

PHYSICIAN-HOSPITAL RELATIONSHIPS

The Subcommittee on Physician-Hospital Relationships has had many meetings, in which clarification of the existing guide has been attempted as well as the incorporation of practical suggestions from the specialty societies and interested members of The Medical Society of New Jersey. One meeting has been held with the executive director of the New Jersey Hospital Association. As of the compilation of this report, another meeting is being scheduled with official representatives of the Hospital Association. Pending such a joint meeting, further reports of this activity must be deferred. If possible, a supplementary report will be available and distributed at the May meeting of the House of Delegates.

Approved (page 332)

GUIDES FOR PHYSICIAN-HOSPITAL RELATIONSHIPS

The accompanying "Guides for Physician-Hospital Relationships" are the culmination of the work of the Council on Medical Services and its Subcommittee on Physician-Hospital Relationships, under the chairmanship of Dr. Francis J. Benz. They have been studied and reviewed by the Board of Trustees—as directed by the 1963 House of Delegates—and are submitted to the House with its unanimous approval.

These "Guides" represent the version which was formally accepted as expressing the ideas and having the approval of a conference committee which met on April 16 and which was attended by three representatives of the New Jersey Hospital Association. The conferees, in approving the present format, have done so only in their individual capacities and have not committed their respective organizations. This version is now submitted to the House of Delegates for its study and formal action. Subsequently, we have been informed, it will be presented to the New Jersey Hospital Association for the formal action of that organization.

The Council on Medical Services offers the proposed "Guides" to the House of Delegates at this time, in the conviction that they have been carefully considered and embody efficiently all basic ideas suggested. It is the hope of the council that the present version will find favor with the House and be adopted, so that the process of implementation may be undertaken without delay.

PROPOSED GUIDES FOR PHYSICIAN-HOSPITAL RELATIONSHIPS IN NEW JERSEY

Introduction

The Medical Society of New Jersey, through its Committee on Physician-Hospital Relationships, sets forth the following principles, together with specific applications of them in the matter of improving the relationship of physicians to hospitals, in the belief that these principles will be IN THE BEST INTEREST OF THE PATIENTS WHOM ITS MEMBERS SERVE. It is hopefully anticipated that the individual hospitals in which our members practice, and the hospitals of the State as a whole, will find the following acceptable.

Section I—Hospital Medical Staff

Members of The Medical Society of New Jersey should expect the hospitals wherein they serve to grant them the following rights, subject to the approval of the hospital Board of Trustees:

1. The right of the active medical staff, or other broadly-based segment of the medical staff, to elect its own officers.
2. The right of the active medical staff, or other broadly-based segment of the medical staff, to review and revoke the actions of medical staff officers, medical staff committees, or medical staff members.
3. The right of the active medical staff, or other broadly-based segment of the medical staff, to nominate and/or elect the chiefs of departments and divisions of the medical staff of the hospital for submission to the board of trustees for their approval.
4. The right of the active medical staff, or other broadly-based segment of the medical staff, to formulate and to revise the bylaws and rules and regulations of the medical staff.

Section II—Relation of Physician to Intern or Resident

Physicians shall be zealous in the teaching of the art of medicine to all house officers assigned to them. They shall not directly or indirectly compensate interns or residents for their services, this being an obligation of the hospital. Nor shall they, without the prior consent of the patient, permit an intern or resident to carry out a procedure or treatment customarily the responsibility of the attending physician.

Section III—Medical Staff Appointment

The hospital staff appointment of a member of The Medical Society of New Jersey should not be revoked nor his reappointment denied unless the following procedures are substantially followed:

1. The Board of Trustees of the hospital taking any action to revoke a medical staff appointment or to not reappoint a member, either to the medical staff or even to the same rank and privilege as previously held, should act only after its proposed action has been considered by the medical staff or its representatives and in accordance with any applicable provisions of the Bylaws of the medical staff.
2. Written notice indicating the grounds for the proposed action should be sent to the medical staff member involved as well as to the medical staff or appropriate medical staff body.
3. Such action aimed at separating a member from the medical staff may be initiated by the medical staff or the governing body, but it must be referred to the proper medical staff committee which will make its report to the medical staff or appropriate medical staff body which, in turn,

shall send the committee report together with its recommendations to the governing body, through the administrator of the hospital.

4. Should the medical staff member involved, or the medical staff, be unwilling to accept the decision of the governing body, a request for a review should be made in writing to the administrator of the hospital within 30 days of receipt of written notice of the governing board's action.

5. A committee of equal representation of the medical staff and the governing body (e.g., Joint Conference Committee) should review the case and send its recommendation within 30 days to the governing body, with a copy to the medical staff or appropriate medical staff body.

6. If the above procedures are not substantially followed, The Medical Society of New Jersey shall lend its good offices to any member it considers unjustly burdened.

A procedure mutually acceptable to The Medical Society of New Jersey and the New Jersey Hospital Association should be adopted whereby a joint committee to review such cases will be created and a method of effective arbitration established.

Section IV—Remuneration of the Physician By a Hospital

While The Medical Society of New Jersey considers it improper for any of its members to accept remuneration from a hospital for the direct medical care of a patient from whom the hospital directly or indirectly receives a fee, it recognizes that in certain less direct types of medical care, usually of a consultative nature, such remuneration is customary and is proper if consonant with the principles that follow. The Medical Society of New Jersey endorses the conclusion as set forth in "Guides for Conduct of Physicians in Relationships with Institutions," adopted by the American Medical Association in December 1951, and reaffirmed by its House of Delegates in December 1959, which reads:

> "A physician should not dispose of his professional attainments or services to any hospital, corporation, or lay body by whatever name called or however organized under the terms or conditions which permit the sale of the services of that physician by such agency for a fee."

The Medical Society of New Jersey likewise endorses the statement made at the same time:

> "Lest there be any misunderstanding, we state unequivocally that the AMA firmly subscribes to freedom of choice of physicians and free competition among physicians as being prerequisites to optimum medical care. The benefits of any system which provides medical care must be judged on the degree to which it allows of, or abridges, such freedom of choice and such competition."

While the manner of remuneration of a physician for professional services rendered to patients in a hospital may have many acceptable forms, any agreement should be judged by the degree to which it satisfies the following conditions:

1. The financial arrangement between a hospital and a physician should be placed on a mutually satisfactory basis, but a physician should not dispose of his professional services and attainments to any hospital, lay body, organization, group, or individual, by whatever name called or however organized, under terms or conditions which permit exploitation of the patient, the hospital, or the physician.

2. The medical staff appointments and reappointments of specialists in anesthesiology, pathology, physical medicine, roentgenology, electrocardiography, medical education, pulmonary function evaluation, and other similar integral parts of the practice of medicine should be governed by the same principles as appointments and reappointments in surgery, internal medicine, and other designated fields of medical practice.

3. The employment of a physician in a professional capacity by a hospital should be consonant with the following considerations:

   a. That the hospital recognize "that as diagnostic and treatment services become more complex it is necessary more and more for hospitals to consult with the medical staff on matters relating to hospital physician specialist relationships. This is particularly true: (a) regarding the specialist's selection where professional qualifications determine the individual to be selected, (b) regarding unresolved problems arising in connection with hospital and physician specialist relationships, including financial problems, and (c) regarding charges made for services." (from "Statement on Hospital and Physician Relationships," adopted by the American Hospital Association, 1959)

   b. That the qualifications for the position should be specified and be made available to all interested parties insofar as is possible and practicable.

   c. That the method of appointment to the position be promulgated. This method should be consistent with the statement from the Joint Commission on Accreditation issued in connection with electrocardiography but applicable to all professional situations:

      > "The interpretation of electrocardiograms is much like any other work in the hospital. It is a privilege that should be granted to a physician or physicians by the Credentials Committee of the staff, taking into account the applicant's training, qualifications, experience, and demonstrated ability." (page 109, Hospital Accreditation references)

   d. That when vacancies occur or are about to occur the fact should be well advertised to the staff and even outside the institution if desirable. The practice of cooptation, that is the selection of their successors by persons already holding positions in the hospital, should be strongly disapproved.

   e. That the payments for such services should be separated into those for supervisory services and those for personally performed professional services.

f. That contracts, terms, and amounts of payment for all in-hospital professional services made subject to contract should be available to the governing body and the medical staff.

g. That the payment on the basis of monthly or yearly salary is proper only for that portion of the physician's services which are supervisory. In any activity wherein the hospital is traditionally compensated on a fee-for-service basis, the physician also should be compensated on a fee-for-service basis for any service he *personally* renders (albeit not necessarily the same fee). Otherwise, the arrangement will violate the principle quoted in the opening paragraph of this section.

h. That rather than restricting such in-hospital medical services to one or a few doctors in each activity, an attempt be made to permit participation of as many qualified physicians as possible. In any event, the remuneration of any physician for any in-hospital professional activity should never be so great as to give the informed person the impression of exploitation or monopoly. Before this state is reached other physicians on the staff should be invited to participate in the activity.

i. That the hospital use the term "fee" to describe the remuneration it pays any physician for his services.

j. That the chief of a hospital department have access to the financial information regarding his department.

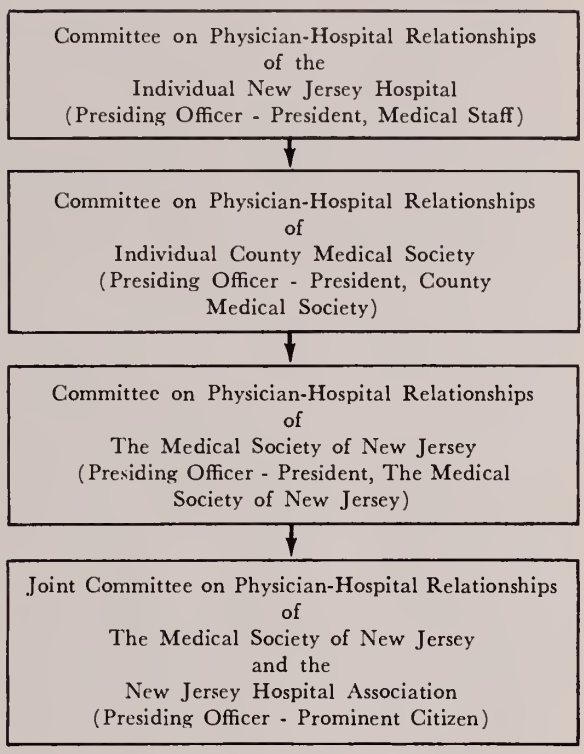
Section V—Grievance Procedures

Any member of a hospital staff who feels that he has a grievance against his hospital shall first attempt to obtain adjustment of this situation within the institution through the joint conference committee of that hospital. Failing in this, he shall be free to present his case before the appropriate physician-hospital relationships committee.

The Medical Society of New Jersey shall appoint a continuing committee to hear any charge of exploitation or other grievance of a physician-member pertaining to a physician-hospital relationship.

If the grievance is not resolved by this committee, it is to be passed on to the proposed Joint Committee on Physician-Hospital Relationships of The Medical Society of New Jersey and the New Jersey Hospital Association for final hearing and disposition.

Procedural Channels Proposed by The Medical Society of New Jersey for Problems Arising in Physician-Hospital Relationships in New Jersey



Section VI—Joint Statement*

It is mutually agreed between The Medical Society of New Jersey and the New Jersey Hospital Association that physicians should not be assessed, but that each physician should be urged voluntarily to contribute to the hospitals of his choice as much as he can donate without hardship, provided that the amount of such contribution is to be determined only by the physician himself; and that no hospital impose any penalties, sanctions or restrictions on any physician by reason of the amount of his donation.

*Proposed by the joint conference committee, meeting on April 16, 1964, subject to formal adoption by The Medical Society of New Jersey and the New Jersey Hospital Association.

Approved (page 332), with the notatian that the terms (1) "active medical staff" and (2) "other braadly-based segment of the medical staff" are not herein defined; their definition should be left to the medical staff of the respective haspitals.

Hause directed that capy be sent to the president and secretary af all medical staffs, haspital administratars, and hospital lay boards in New Jersey (page 332).

PUBLIC HEALTH

John B. Fuhrmann, M.D., Chairman, Flemington

(Reference Committee "G")

TUBERCULOSIS CONTROL

The 1963 House adopted resolution #13, which was referred by the Board of Trustees to the Council on Public Health—the "resolves" of which read:

Resolved, that The Medical Society of New Jersey study the current situation in the attack on tuberculosis, and in particular the recommendations of the Amberson Committee, and the role the State should now play in the financing and coordination of local efforts against tuberculosis; and be it further

Resolved, that the appropriate committee of The Medical Society of New Jersey be directed to consider and report to the Board of Trustees on these matters by October 1, 1963.

The council was informed of the latest activities of the State Council on Tuberculosis. Under date of June 17, 1963, Commissioner of Health Kandle announced to all physicians the availability, upon request, of the Amberson report, Diagnostic Standards and Classification of Tuberculosis by the National Tuberculosis Association, Guide for the Physician in Drug Treatment of Tuberculosis (Standards for Chemotherapy), and Goals and Standards for the Control of Tuberculosis in New Jersey. Also included was a statement of "The Use of Chemotherapy as a Public Health Measure in Tuberculosis" by the American Thoracic Society, which was fully endorsed by the State Council on Tuberculosis. The Department of Health has set specific detailed goals for eradication of tuberculosis in this decade. Advances have been made; standards of chemotherapy have been established; and the Department has state money for indigent patients. It was the action of the council that state funds should be set aside to pay the per diem cost of the tuberculosis patient not only in county hospitals, but in city hospitals also. Too frequently the patient must be held in the city hospital until a room is available in the county hospital, and during his stay in the city hospital the cost has to be absorbed from local funds without help from state funds.

The Board approved the recommendation of the Council on Public Health that the following paragraph be added to the resolution:

Resolved, that The Medical Society of New Jersey emphasize and endorse the principle of state payment of full cost in city as well as county hospitals for **medically indigent** tuberculous patients.

Amended to include the words "medically indigent," as indicated.

Approved as amended (page 333)

REPORTING OF COMMUNICABLE DISEASES

Resolution #12—as amended and adopted by the 1963 House of Delegates—urged "that The Medical Society of New Jersey recommend that the three categories of disease—namely, epilepsy, cerebral palsy, and mental deficiency—be stricken as reportable diseases. This matter was referred by the Board to the Council on Public Health. The council was informed that the Sanitary Code is undergoing extensive revision, and that the proposed revision of Chapter 2, Regulation 1, will not include epilepsy, cerebral palsy, and mental deficiency as reportable diseases. Under the proposed revision recently presented to the Public Health Council of the New Jersey State Department of Health, the following would be deleted from the list of reportable diseases: cerebral palsy, epilepsy, influenza, measles, mental deficiency, whooping cough, pneumonia, and streptococcal sore throat. Louse-borne relapsing fever would be added to the list of reportable diseases.

Approved (page 333)

CIGARETTE SMOKING AND LUNG CANCER

At the final 1962-63 Public Health Council meeting, the problem of cigarette smoking and lung cancer was brought up for discussion. Through the efforts of several council members and with the cooperation of both the Cancer Control Committee of The Medical Society of New Jersey and the Medical Committee of the New Jersey Division, Inc. of the American Cancer Society, your council supported the following resolution concerning this topic, which was published to the membership shortly after its having been approved by the Board of Trustees on December 15, 1963:

Whereas, there is definite statistical and apparent scientific evidence that lung cancer is more frequent in cigarette smokers than in nonsmokers; and

Whereas, The Medical Society of New Jersey lists as one of its constitutional purposes "to promote the betterment of public health; and to enlighten and direct public opinion in regard to the problems of medicine and health for the best interests of the people of New Jersey;" and

Whereas, increasing incidence of fatal lung cancer is undeniably one of the pressing health problems of our day; now therefore be it

Resolved, that The Medical Society of New Jersey call upon the people of New Jersey to recognize the intimate connection between sustained cigarette smoking and lung cancer, and encourage:

1. Those individuals who do not smoke cigarettes never to initiate the habit of smoking, and
2. Those individuals who do smoke cigarettes to abandon, or restrict, their indulgence.

Approved (page 333), with the suggestion that the AMA be more positive in its approach to the cancer problem and smoking; and through state and local societies and individual physicians, carry its message to the public; also the harmful effects of smoking in conditions other than cancer should be emphasized; for example, in heart disease.

SEWAGE DISPOSAL POLLUTION

An additional subject considered at several meetings of the council was that of pollution due to sewage disposal in rivers, especially along the Atlantic Coast. This was discussed at length; and with the advice of the Commissioner of Health and the approval of the Board of Trustees, this matter was referred to the local counties wherein the pollution occurs. The various county medical societies and the various local boards of health are all-powerful in these matters. It was the opinion of the council that these matters are extremely important towards future public health legislation, and the council stands ready to offer any assistance that it may in helping to control this public health nuisance.

Approved (page 333)

SPECIAL COMMITTEES

The business of the Council on Public Health is divided into two phases. One is the reception and discussion for approval or rejection of the reports of the various Special Committees assigned to the council. The second is the discussion and eventual approval of topics and projects of general public health interest in New Jersey. As The Medical Society of New Jersey is the spokesman for the physicians of New Jersey, so also the Council on Public Health should, with the approval of the Board of Trustees or the House of Delegates, be the spokesman for the physicians of New Jersey on public health matters when such are brought to its attention.

Briefly concerning the special committees: It is the feeling of the council members in general, and of its chairman in particular, that the special committee structure needs re-evaluating and re-constituting. Most of the special committees did not meet the required number of times this past year and several of them performed no special function during the course of the year. This is not true of all; as you will observe from reading their own committee reports.

Some performed very valuable tasks as follows:

1. Mental Health . . . with the New Jersey Congress for Mental Health scheduled for September 1964.
2. Child Health . . . with its Workshop on School Health on March 17, 1964.

MISCELLANEOUS

It was the concurring opinion of the council members that in the field of New Jersey State public health matters lies the real purpose of the council; and it is in this field that an attempt will be made in the future to offer an additional important help to New Jersey public health. A plea was issued to all council members and to chairmen of special committees to submit to the council any matters concerned with public health that should be considered during the coming year.

Again this year, I wish to thank the Commissioner of Health, Dr. Roscoe Kandle, and the Department of Health of the State of New Jersey generally, for the kind help and cooperation afforded the council by them during our meetings. Their advice and support meant much to the work of the council. Also my personal thanks to each member of the council who participated in the work this year and to the chairmen of the council's special committees for their contributions to our efforts.

RECOMMENDATION

That the Board of Trustees of The Medical Society of New Jersey appoint an appropriate committee to study the special committee structure of its organization, with the thought in mind of streamlining the number of committees when their function seems to have lost substance.

Approved (page 333)

Approved as amended (page 333)

PUBLIC RELATIONS

John F. Kustrup, M.D., Chairman, Trenton

(Reference Committee ("E")

The Council on Public Relations recognizes that the best public relations for the medical profession can be achieved by the dedicated and conscientious practicing physician. But supportive of and complementary to the individual physician's endeavors in this vital area are the programs and projects of organized medicine. In that spirit and in that conviction, your Council on Public Relations carries on. It invites your interest and invaluable cooperation.

CONTINUING PROJECTS

At its reorganization meeting last year, the council adopted, and the Board subsequently approved, the following projects, for 1963-64:

(1) Publication and distribution of:

(a) *Junior Health Hints* to secondary schools and public libraries

(b) *Health Hints* to the press, house organs, and other media, over the signature of "Michael S. Newjohn, M.D." on a semi-monthly basis.

(c) *Membership News Letter,* including the annual compilation of a bound, indexed set for each component society

(d) *Periodic Newsletter* to cooperating agencies and individuals (as required)

(2) Preparation and publication of special news releases and publicity as required from time to time in furtherance of the Society's business and interests, including:

(a) 1963 Eye Health Screening Program
(b) 1964 Annual Meeting
(c) 1964 Child Safety Week
(d) Selected official programs and activities

(3) Responsibility for the designation of recipients and the ceremonies of bestowal of the Golden Merit Award

(4) Responsibility for the press room and press and publicity contacts and releases at the Annual Meeting

(5) Maintenance of press clipping service for the Society's public relations features, releases, and press notices

(6) Continuance of consultative service in support of the public relations activities of component societies

(7) Encouragement of indoctrination programs under the sponsorship of the component societies

(8) Preparation and distribution of a membership service kit

EMERGENCY MEDICAL CALL SYSTEM

One of the most important areas of concern to the council this year has been the necessity of again urging upon all component societies and all members individually the obligation of maintaining operationally adequate emergency call systems in all areas of the state. Since the late 1950's—on the basis of recommendations supplied through the council—component societies have been committed to the maintenance of such coverage. The council—through the Board of Trustees—has repeatedly emphasized this program as an indispensable and highly important aspect of public relations and public service. The council offers consultative assistance to component societies that find themselves in need of it in this area.

CIGARETTE SMOKING

In an effort to call attention to the problems and hazards of smoking for young people, the council was instrumental in distributing to the 1,430 PTA organizations throughout New Jersey copies of a scientific article reporting the results of a survey on "The Smoking Habits of School Children," which appeared in the September issue of THE JOURNAL.

The council also issued a special press release to newspapers and component societies in January 1964 outlining the Society's opposition to cigarette smoking.

In view of the research program undertaken by the AMA and of the many other positive actions being taken at this time, the council feels that further action in this area is not necessary.

GOLDEN MERIT AWARD

This year The Medical Society of New Jersey will honor the largest number of Golden Merit Award recipients since the establishment of the award by the council in 1957. A total of 43 candidates will receive the 1964 citation in conjunction with the Annual Meeting in Atlantic City.

As the result of specific inquiries concerning posthumous conferral, with the approval of the Board of Trustees decision has been taken that the Golden Merit Award will be granted to all candidates who are alive as of January 1 of their 50th postgraduate year. If the candidate dies between January 1 and the date the award is made, his plaque will be sent to his next of kin.

Because of the overwhelming success last year of the first social hour for Golden Merit Award recipients and their families immediately following the bestowal ceremonies, this added feature of the convention will, with Board approval, be made a permanent annual event, and hereafter its financing will be provided for in the council's annual budget appropriation. Each year invitations will be extended by the Council on Public Relations to the recipients and their immediate families, and to members of the Board of Trustees and to the presidents of component societies acting as marshals.

MEMBERSHIP GUIDE KIT

Upon recommendation of the council—approved by the Board—the next edition of the *Membership Directory* will have a special supplement containing those informational materials planned for separate compilation and mailing to members in a proposed "Membership Guide Kit," namely—the Constitution and Bylaws of MSNJ, the Principles of Medical Ethics, a list of Poison Control Centers, and a precis of the Legal Hazards of Medical Practice. The council is convinced that such a supplement would be less costly, more convenient for the members' use, and easier to keep current.

Approved (page 330), with recommendation to the Council for its effectiveness.

Special Committees to the Administrative Council on Medical Services . . .

OCCUPATIONAL HEALTH

Delma W. Caldwell, M.D., Chairman, Linden
(Reference Committee "F")

During the past year the committee was responsible for republication in the State Medical Journal of the plea to all doctors to bring up to date tetanus immunization of their patients.

The annual joint meeting with the Committee on Workmen's Compensation was held. The major advantage to this meeting is, of course, in the direct personal interchange of information among the members of the two committees.

The committee unfortunately was unable to progress at all with its plan to publish three or four times during the year in the State Journal general articles in the field of occupational health.

Slight progress was made in contacting county societies for the purpose of stimulating interest on the part of existing occupational health committees or initiating the formation of such committees within the county societies.

As chairman of this committee for the second time, I would propose that some method be established whereby effective members for the committee be assigned from the southern part of the state. I think that this will not only make for new blood in the committee, but will enhance the committee's state-wide interest.

I would further propose that more careful selection of candidates for the committee be considered. By this proposal I definitely do not wish to detract from the interest and loyalty shown by Dr. Lloyd Hamilton, Dr. Edmund Hartmann, Dr. Willis Mitchell, Dr. Mathilda Vaschak, and Dr. William VanRiper.

Lastly, not wishing to sound presumptuous, I would like to propose that two terms as a committee chairman is neither too much nor too little.

I have enjoyed working with the committee. I think that such a committee, under forceful leadership and equally forceful support by the State Society, is in a position to be quite effective. I express my thanks for the Society's appointing me during the past two terms to the committee.

Received as progress report (page 332)

WORKMEN'S COMPENSATION

Joseph A. Lepree, M.D., Chairman, Elizabeth
(Reference Committee "F")

A joint meeting of the Special Committee on Workmen's Compensation and the Special Committee on Occupational Health was held on December 1, 1963.

The following recommendations were adopted:

1. That the members of The Medical Society of New Jersey be reminded that the function of the physician in court is to render an honest and reasoned medical opinion as a medical witness, not to serve as a legal adversary, and that he is expected to prepare his testimony carefully and impartially, and to be a representative of the truth as he knows it, as a responsible physician.

2. That since the Joint Legislative Workmen's Compensation Study Commission has ignored the recommendation of The Medical Society of New Jersey, the joint committees recommend to the Board of Trustees of The Medical Society of New Jersey that further action be taken with the State Department of Labor and Industry with regard to the evaluation of disability from the viewpoint of physical impairment to be evaluated by physicians, and permanent disability to be evaluated by an impartial group—as recommended by the American Medical Association and adopted by The Medical Society of New Jersey.

Approved (page 332)

Special Committees to the Administrative Council on Public Health . . .

CANCER CONTROL

John L. Olpp, M.D., Chairman, Englewood

(Reference Committee "G")

The committee endorses periodic health examinations. Each examining physician's office shall serve as a cancer detection clinic. Publicity for periodic examinations should originate in, and be disseminated by, the component county medical societies and be coordinated with the programs of the local chapters of the National Cancer, Heart, and Tuberculosis Associations.

Mammography is deemed useful as a diagnostic aid in examination of the breast. Mass screening is expensive and its value questionable. In fact, the procedure is still limited in scope and availability due to paucity of experienced radiologists and adequately trained technicians.

The Bergen County Central Tumor Registry has been functioning for two years and as of April 1, 1964 contains 3,640 cases. Seventy per cent of the registered cases are being followed. The Registry serves as the clearing house for cancer cases diagnosed and treated in the County. As the statistics become available, we will have a more accurate incidence of cancer in Bergen County.

RECOMMENDATIONS

1. That all physicians have annual physical examinations on or near their birthdays. The members of the Women's Auxiliary should also have annual examinations and should encourage their husbands to be examined.

2. That mammography be used in selected cases, and not advocated for cancer screening at this time.

3. That another survey of New Jersey hospitals be conducted in 1964-65 to determine the status of tumor registries.

Approved (page 333)

CHILD HEALTH

Robert E. Jennings, M.D., Chairman, South Orange

(Reference Committee "G")

Two meetings of the Special Committee on Child Health were held during the year 1963-1964.

In June 1963, a member of our committee met with a committee of the State Federation of the Boards of Education to attempt to find common ground for a discussion of Section 18: 14-17 of the Revised Statutes, Chapter 25 of the Laws of New Jersey, requesting mandatory examination by the school physician.

In October 1963, it was the pleasure of your Chairman to represent the Society at the 11th Conference of Physicians and Schools in Chicago, Illinois. The theme of this conference was the need for greater communication between the school physician, the family physician and the school administration.

At the request of The Medical Society of New Jersey, Governor Hughes proclaimed the week of April 6, 1964 as "Child Safety Week." Anticipating this proclamation, the Child Health Committee met with the Child Health Committee Chairmen of each component medical society. Methods and materials were furnished for the establishment of a Mayor's Committee on Child Safety, in each community, throughout the state. These would be sponsored and supervised by members of the local Medical Society cooperating with the Health Officers. Lay members of the community were encouraged to participate. It is hoped that these will be con-

tinuing committees. As a basis for the *Program on Child Safety,* the papers presented at the "Symposium on Child Safety" in April 1962—sponsored by the MSNJ—were published together in a special edition on "Accident Prevention" in *Public Health News,* the official journal of the New Jersey State Department of Health.

The Medical Society of New Jersey co-sponsored a "Workshop for School Physicians" at the Brunswick Inn, East Brunswick, on March 11, 1964. This was held in cooperation with the New Jersey State Department of Health and Education. Doctor Robert Fleming was the principal speaker.

The Chairman of the Child Health Committee spoke before the New Jersey Chapter of the Academy of General Practice in January 1964 at Atlantic City. This was undertaken to promote interest in the proposed New Jersey Association of School Physicians.

The Steering Committee for the New Jersey Association of School Physicians has proposed and had adopted the Constitution and By-Laws of this Association. A luncheon meeting of this association will be held on Monday, May 18, 1964, when officers will be elected.

Following the "Symposium on the Seriously Injured Child" presented at the annual meeting of The Medical Society of New Jersey in May 1963, this committee is currently preparing a "Handbook on the Seriously Injured Child" for use in the emergency rooms of hospitals.

The committee urged cooperation with the Youth Division, State of New Jersey—and its subcommittee on the Battered Child, to institute a survey on the prevalence of this condition. This was to support proposed protective legislation in this field of concern.

Approved (page 333), with commendation to the committee for its excellent work during the past year.

CHRONICALLY ILL AND THE AGING

Matthew E. Boylan, M. D., Chairman, Jersey City

(Reference Committee "G")

The activities of the Committee on the Chronically Ill and the Aging were centered in one meeting.

It was approved that the Committee receive and participate in the activities set forth in an informational bulletin to be presented periodically by the A.M.A. Committee on Aging.

The bulletin reports on three general areas:

1. Activities of the A.M.A. Committee on Aging and implications for local follow-up.
2. Activities and programs conducted by various state and local society committees on aging.
3. Activities of other national and local groups, including perhaps legislative trends where appropriate.

Such a bulletin is now a reality and is issued quarterly to the state and component societies.

Along the lines of closer cooperation with the A.M.A. Committee on Aging, David B. Allman, M.D., of our own Society, a member of the A.M.A. Committee, has been designated as representative to attend our committee meetings.

It had been clearly indicated that there is an increasing and relatively high incidence of tuberculosis in the elderly age group of citizens. On the recommendation of the Committee, the Board of Trustees adopted the following motion:

"That The Medical Society of New Jersey urge its members in their general physical examination of elderly individuals to do routine x-ray tests to rule out tuberculosis."

Amended to read: "That The Medical Society of New Jersey urge its members in their general physical examination of elderly individuals to do routine chest x-rays to rule out tuberculosis."

Approved as amended (page 333)

CONSERVATION OF HEARING AND SPEECH

James H. Spillane, M.D., Chairman, Phillipsburg

(Reference Committee "G")

The committee has continued to follow the progress of the Speech and Hearing Centers throughout the state and has met with members of the New Jersey Chapter of the American Speech and Hearing Association. It is felt by the committee that a close relationship is being developed which should be of mutual benefit.

Your committee has continued to cooperate with the Division of Constructive Health of the State Department of Health as their school screening program goes into effect. The committee's exhibit at the 1964 convention deals with the school screening program. It contains informative material on the types of hearing loss and disease processes affecting the 5-17 age group and offers a model screening program.

Our major project for the coming year will be extension of screening procedure to the preschool child and the adult, coupled with an educational program to instruct the public as to the proper procedure to follow when a hearing impairment is suspected.

Approved (page 334)

CONSERVATION OF VISION

Ralph E. Siegel, M.D., Chairman, Perth Amboy

(Reference Committee "G")

EYE HEALTH SCREENING PROGRAM

For the seventh consecutive year, The Medical Society of New Jersey through its Special Committee on Conservation of Vision sponsored a state-wide "Eye Health Screening Program" during the third week in September. The program was supported by the New Jersey Academy of Ophthalmology and Otolaryngology, the New Jersey State Commission for the Blind, the New Jersey State Department of Health, and the New Jersey Hospital Association.

This screening program for the detection of eye diseases is carried out in most of the hospitals in New Jersey and is open to all persons over the age of 35 years. The total number of persons screened was 8,157; an increase of 5% over 1962 and the largest number ever tested under the program. Of the number screened, 5.7% were tonometry positive or glaucoma suspects.

The Eye Health Screening Program serves a very useful public health function, since it not only detects many cases of previously unsuspected glaucoma and other eye defects but also alerts the public to the importance of early ophthalmological diagnosis and prompt treatment. This program is undoubtedly one of the Society's better public relations projects and should be continued.

SCHOOL EYE SYMPOSIUM

Your Committee, in cooperation with the Commission for the Blind, presented in Newark, a well-attended Eye Symposium for School Personnel covering the counties of Essex, Hudson, and Union. The panel dealt with a wide range of timely topics and brought to the attention of nurses, principals, and teachers the newer aspects of visual problems among school children. **Reference committee suggested that MSNJ encourage other counties to support similar symposia in their areas.**

RECOMMENDATIONS

1. That the House of Delegates approve the continuation of the Eye Health Screening Program, scheduled for the month of September 1964.

2. That continuance of the School Eye Symposium Programs be approved.

Approved (page 334)

MATERNAL AND INFANT WELFARE

John D. Preece, M.D., Chairman, Trenton

(Reference Committee "G")

In the past year, the Special Committee on Maternal and Infant Welfare has completed its classification of the maternal deaths in New Jersey for 1963. In the December issue of THE JOURNAL of The Medical Society of New Jersey, the committee published an article warning of the high incidence and the high mortality of septic abortions.

There has been a discrepancy between the committee's classification of maternal deaths and those of the State Bureau of Vital Statistics. This is not an uncommon situation in other states as well as in our own. However, it is the desire of the two departments that our statistics should agree. Therefore, in the coming year the Special Committee on Maternal and Infant Welfare will work with the New Jersey Department of Health on a correlation of our classification of maternal deaths with that of the Bureau of Vital Statistics.

The Bureau of Vital Statistics has indicated that in 1964 it will report all death certificates to the Department of Maternal and Child Welfare on which pregnancy is mentioned, in any way. This will help us to avoid missing any categories of maternal deaths which may have escaped us in the past. With this additional cooperation we hope to have more complete records in the future.

Approved (page 334)

MENTAL HEALTH

Robert S. Garber, M.D., Chairman, Belle Mead

(Reference Committee "G")

The committee continues to concern itself with two major problems which remain unresolved:

1. The pending legislation which would modernize the existing mental health laws (enacted in 1919) continues to remain in "status quo"—i.e., no action.
2. The recurrent problem created by the requirement of *all* physicians to report cases of epilepsy (enacted in 1912) has not resulted in any acceptable new legislation. This continues to place on all physicians the onus of reporting "seizure problems" rather than the emphasis placed on the individual patient.

The committee is pleased to note that 15 of our county mental health committees have held local county congresses on mental health. The result of their combined efforts will be incorporated in our Statewide New Jersey Congress on Mental Health, which will be held on Thursday, September 17, 1964, at the New Jersey Neuro-Psychiatric Institute in Princeton.

Your chairman has served as a member of the AMA Planning Committee for the Second AMA Congress on Mental Health, to be held in Chicago, November 5-7, 1964.

Your attention is drawn to each of these congresses (local and national) because the "prime audience-target" is every individual physician regardless of his specialty.

RECOMMENDATION

Whereas the existing mental health laws enacted in 1919 are antiquated in terms of modern psychiatric understanding and research, attending legislation looking to modernization of existing statutes should be actively supported by The Medical Society of New Jersey.

Approved (page 334)

REHABILITATION

Elmer J. Elias, M.D., Chairman, Trenton
(Reference Committee "G")

The committee has met on several occasions to determine the feasibility of establishing a Directory of Rehabilitative Services available in New Jersey. It has been generally agreed that such a directory would be a valuable asset not only to the medical profession but to other agencies as well.

The following report—submitted to the Board of Trustees at its meeting on February 16, 1964—and the Board's action concerning it will serve as a summary of the thoughts accumulated:

To implement the committee's recommendation—which has been approved—that it start collecting the desired information on rehabilitative services and facilities in New Jersey, with such help as can be provided through the Executive Offices—the following recommendations were unanimously adopted:

1. That a communication from the committee be sent to the president of each component medical society explaining the purposes for compilation of a Directory of Rehabilitative Services and Facilities in New Jersey;

2. That each county committee on rehabilitation be requested to compile a directory of rehabilitative services and facilities available in its county; and that the directory information cover the following:

Health and Hospital Services
- Ambulance service and rescue squads
- Departments of Health
- Health Services—Mental Retardation
- Health Services—Psychiatric-Neurologic, etc.
- Health Services—General and not otherwise classified
- Homes for convalescent and handicapped
- Hospitals, general
- Hospitals rendering special services
- Nursing services

Vocation, Rehabilitation and Guidance Services
- Guidance Centers
- Guidance Departments in Education
- Vocation and Rehabilitation Services

Classified Index

Other Directories of Society Welfare Services

3. That a joint meeting of the special committee with the chairmen of county committees on rehabilitation be held in Trenton during the first week of April 1964—exact date and time to be specified later.

In view of the confused situation existing at this time, and because under the Kerr-Mills implementing legislation in New Jersey the responsibility to compile a directory of facilities is imposed upon the state, and in light of the earlier action of the Board disapproving the compilation of such a directory by The Medical Society of New Jersey, the foregoing recommendations submitted by the Committee on Rehabilitation were tabled.

The action of the Board of Trustees leaves the Committee on Rehabilitation with no further incentive for investigation toward the compilation of a directory. The committee sincerely hopes that the Department of Institutions and Agencies of the State of New Jersey will fulfill its obligation toward compiling the Directory of Rehabilitative Services which may become available to the physicians of New Jersey, and that we, as physicians, will have no cause to complain of any deficiencies that may occur in this service for the future.

Approved (page 334)

Special Committees . . .

DISASTER MEDICAL CARE

Jack R. Karel, M.D., Chairman, Hillside

(Reference Committee "H")

As in the previous year, the problem of the Special Committee on Disaster Medical Care was to bring the medical profession an awareness of its basic responsibility of preparing for, and assuming the management of, mass casualties during a grave national disaster. This clearly set the direction for disaster planning among the component medical societies, where action must be generated. In line with this, the accomplishments of the committee were as follows:

1. The first New Jersey Health Mobilization Institute was held in Newark on February 18-19, 1964 in cooperation with the New Jersey State Department of Health, New Jersey Division of Civil Defense and Disaster Control, Health Mobilization Service of the U. S. Public Health Service, and the Health Mobilization Training Section of the Communicable Disease Center of the U. S. Public Health Service.

2. At the annual meeting in May 1964, there will be a Symposium on Emergency Preparedness and the Physician, with authoritative speakers from the Division of Health Mobilization in Washington, D. C., American Medical Association, and the New Jersey State Department of Health.

3. There will be an exhibit at the 1964 annual meeting. This will be the first presentation of a 200-Bed Civil Defense Emergency *Training* Hospital now assigned permanently to New Jersey.

Approved (page 336)

NURSING EDUCATION AND RECRUITMENT

Jesse McCall, M.D., Chairman, Newton

(Reference Committee "H")

In response to the action by the 1963 House of Delegates that The Medical Society of New Jersey sponsor the establishment of a Permanent Joint Committee on Nursing Education and Recruitment, an organization meeting was held in Trenton consisting of representatives from the following groups: The Medical Society of New Jersey, New Jersey State Nurses' Association, New Jersey Hospital Association, New Jersey League for Nursing, New Jersey Board of Nursing, New Jersey nursing schools, and a representative from the New Jersey State Department of Education.

Enthusiastic and animated informal discussion led to the following conclusions—agreed upon by all present:

> Definite need exists in New Jersey at the present time for (1) more nurses; (2) more facilities for training nursing personnel—preferably affiliated with hospitals; (3) additional personnel for teaching nursing; and (4) more money to educate nurses.

Everyone agreed that there exists in New Jersey a shortage of nursing personnel which threatens to become increasingly serious. It was also agreed that the expanded modalities of hospital and medical practice and the construction of additional hospital beds have created a demand for more nurses. Yet no related provision for expansion of nursing education has been provided. One of the more serious problems accounting for the shortage of nursing personnel is the high percentage of dropouts. It was also generally agreed at the meet-

ing that another problem is the lack of sufficient educational facilities and personnel. In New Jersey today, it was reported, there are only 34 diploma (R.N.) schools and 3 collegiate programs for nursing. Also discussed was the need for funds for nurses' training, since hospitals are finding it increasingly difficult to absorb the heavy deficits of nursing schools—especially since the return to hospitals of nursing services is minimal. It was pointed out that, although New Jersey makes scholarship funds available for students interested in pursuing college careers, such funds are not available for students pursuing nursing careers.

To define the aims and objectives of the group and to evolve recommendations as to effective means calculated to realize those aims and objectives, a subcommittee was formed consisting of one representative each from the following: New Jersey State Nurses' Association, New Jersey Hospital Association, New Jersey League for Nursing, New Jersey Board of Nursing, New Jersey nursing schools and New Jersey nursing education. The group elected its own chairman and secretary, and set a date for its first meeting. This subcommittee will report back to the full committee at a later date.

At the direction of the 1963 House, through this committee the Society petitioned the Governor to hold a special conference on nursing recruitment, using the groups named above and adding any necessary public officials. Inasmuch as the Governor has not moved to call such a conference, the committee agreed that it would not press such action until such time as the subcommittee had reported back to the full committee and the committee had crystallized its program and recommendations.

Approved (page 335), with commendation. The following recommendations were adopted for consideration by the committee:

1. That wherever possible, more students of nursing be accommodated by allowing first-year students to live outside of dormitories.

2. That further acceptance of male nurses be encouraged.

3. That state scholarships for student nurses be sought, similar to scholarships granted for college students.

4. That hospitals operating nursing schools be encouraged to preserve them.

5. That more realistic salaries for nurses be adopted to encourage students to enter and to stay in nursing.

RETIREMENT PLAN FOR PHYSICIANS

Nicholas E. Marchione, M.D., Chairman, Vineland

(Reference Committee "D")

The Special Committee on Retirement Plan for Physicians has been working in conformity with Resolution #18, as amended and adopted by the 1963 House of Delegates, which provided:

1. That the Committee on Retirement Plan for Physicians be authorized and empowered by the House of Delegates to set up and implement a plan of retirement for the physicians of New Jersey on a group and voluntary basis, which shall meet the requirements of the appropriate Internal Revenue Code, and be submitted for review and approval by the Board of Trustees of The Medical Society of New Jersey, and
2. That once the plan has met the foregoing requirements, its availability to the membership on an entirely voluntary basis be publicized in the *Newsletter* and THE JOURNAL of The Medical Society of New Jersey.

Throughout the year, the members of this committee, individually and collectively, reviewed and discussed the many plans submitted by interested individuals and groups, including the AMA Members Retirement Plan and the Mercer County Medical Society Plan. It was the consensus of this committee that any plan should include annuities and equities and possibly include life insurance coverage.

Finally, on December 15, 1963, the committee submitted to the Board of Trustees several plans, including the two mentioned above. At this meeting, several of the committee members were present at the invitation of the President

and the members of the Board of Trustees. After much pointed and cogent discussion, the Board of Trustees chose to table the matter and presented reasons as the basis for the Board's action. These reasons were well set forth in a Board statement supplied by direct mail to all members, under date of December 17, 1963. (A copy of that statement is appended to this report for easy reference.)

Primarily, the Board felt that the MSNJ should not undertake the sponsorship of a State Plan until such time as the IRS rulings become favorable to such action and when further information is obtained as to any pending legislation which might improve the benefits available for physicians, especially those who employ more than one person. Furthermore, the Board of Trustees felt that no individual would be penalized by the Board of Trustees' action, inasmuch as there are currently available the AMA members plan and an unlimited number of individual privately sponsored plans which have been approved by the IRS and SEC. It is urged that the House of Delegates and each other member refer to the Board's statement. In view of the Board's action, the committee took no further action.

A recent AMA news release—under the date line of March 30, 1964—made note that the IRS indicated that it will permit transfer of funds from one exempt pension trust established under the Keogh law to another such pension trust without realization of income, provided there are no curtailments of benefits as a consequence of the transfer, and provided that the new trust be substituted for the old trust by amending the old plan to provide for the substitution.

RECOMMENDATION

That the Committee on Retirement Plan for Physicians be continued so that it may, from time to time, advise the Board of Trustees and the House of Delegates of any new changes in the law or the IRS ruling which might at some future date make a state plan feasible.

Approved (page 329)

STATEMENT ISSUED BY BOARD OF TRUSTEES, DECEMBER 17, 1963

On November 24, 1963, The Medical Society of New Jersey's Committee on Retirement Plan for Physicians approved two plans: (1) the Mercer County Medical Society's Plan through Mutual of New York; and (2) Bankers' National Life Insurance Company of Montclair Plan. Each was recommended to the Board of Trustees on December 15, 1963, for consideration in determining the best plan for MSNJ members.

The Board of Trustees chose to table the matter. This action arose from the conviction that adoption of any plan at this time would be premature, and the following reasons are the basis for the Board's action:

1. The Mercer County Plan has not as yet been approved by the Internal Revenue Service.

   The reference committee noted that this plan has now been approved.
2. The Bankers' Life Plan has been temporarily withdrawn in view of that company's connection with the AMA Plan through affiliation with Scudder, Stevens and Clark.
3. At least one plan approved by IRS and SEC (AMA or individual) is currently available to members.
4. Further study must be given to all of the considerations necessary to determine the best plan to be submitted, in the name of MSNJ, for approval by IRS.
5. The benefits to be derived today from any plan are minimal; in fact, there appears to be no benefit to any physician employing more than one person.

   The reference committee felt this should be called to the attention of the House of Delegates, in that there are benefits to be derived from any available plan if a physician employs no more than one person. If a physician employs more than one person, the benefits begin to decrease.
6. The burden on MSNJ in securing IRS approval is real and should not be undertaken in contemplation of future change, since any approved plan must be designated as permanent in nature.
7. Anticipated federal legislative changes, perhaps even in 1964, will improve the benefits available under a plan subsequently approved and might necessitate the redoing of a plan approved prematurely.
8. Before any member decides to participate in any plan, it is recommended that he consult with, and seek the advice of, his attorney and/or accountant, or both.

Approved (page 329), with the recommendation that a survey of our members be made to determine the number of physicians who have no employees or employ no more than one person. The reference committee feels that this should help the Committee on Retirement Plan for Physicians in its decision as to whether a plan of this nature should be instituted in New Jersey.

TRAFFIC SAFETY

William L. Sprout, M.D., Chairman, Salem

(Reference Committee "G")

At the 197th Annual Meeting, the Special Committee on Traffic Safety presented an educational exhibit titled "Packaging the Passenger," showing how injuries may be prevented or reduced in severity by the use of instrument panel padding, flexible steering wheels, improved door latches, and seat belts.

The committee has also been considering, with the Division of Motor Vehicles and the Advisory Council to the New Jersey Consultation Service for Convulsive Disorders, legislation to provide for the reporting directly to the Division of Motor Vehicles of conditions which repeatedly or continuously result in limitation of a driver's ability to operate a vehicle with safety to himself and others. The law presently in effect states as follows:

"The physician in charge of a case of mental deficiency or epilepsy and the medical inspector having supervision of any school, when he has reason to believe that any person attending the school is mentally deficient or is epileptic, shall report the case to the assessor of the township in which the person resides. The report shall be in writing, signed by the maker, and shall set forth the name, age, and precise location of the person reported as being mentally deficient or having epilepsy" (R.S. 26:5-1).

This portion of the statute was circulated to the membership in the September 1963 Newsletter. In clarification of this statute, an opinion was obtained by the Commissioner of Health from the Office of the Attorney-General which stated that the responsibility for making such a report lies with the physician treating the epileptic patient for his epilepsy, and does not extend to involve other physicians who might treat the same patient from time to time for other conditions.

The newest paragraph of the Attorney-General's opinion issued under date of December 31, 1963—follows:

In our opinion R.S. 26:5-1 does not require all physicians who learn of a case of epilepsy to make the report, but only the physician "in charge of a case of . . . epilepsy." This is made clear by this section since it also provides that the medical inspector having supervision of any school must make the report "when he has reason to believe" that any person attending the school has epilepsy. The contrast between the requirement for a report by the physician "in charge" of a case of epilepsy and the requirement for a report from a school medical inspector when he has "reason to believe" that a person attending the school has epilepsy impels the conclusion that the section does not require a report from a physician who learns only incidentally or "has reason to believe" a person has epilepsy, so long as the physician is not actually treating the patient for epilepsy as such and, therefore, cannot be considered "in charge" of a case of epilepsy.

The Division of Motor Vehicles has suggested repeal of R.S. 26:5 and also elimination of the required reporting of epilepsy and mental deficiency to the local health officer under the State Sanitary Code. They suggest a new law which would require a physician to report to the Division of Motor Vehicles directly, any case involving a patient 16 years old or older when, in the opinion of the physician, the patient suffers from a condition which would make him physically unqualified to operate a motor vehicle with safety to himself and others. "The physician should be required to report only after he has properly diagnosed and evaluated his patient's condition and disability to his professional satisfaction."

In considering this suggestion from the Division of Motor Vehicles, the committee feels that the physician needs to be better informed about the conditions which are most likely to result in such driver limitations. A comprehensive statement of such conditions was adopted by the A.M.A. House of Delegates on December 4, 1963, and has already been published in the J.A.M.A. for February 1, 1964. The basic principles of this statement appear in the recommendations at the end of this re-

port, and their adoption as an expression of the position of The Medical Socicty of New Jersey is urged.

The committee understands that the Division of Motor Vehicles would like to make arrangements for direct reporting of all conditions of this sort directly to the Division; however, it questions whether it is feasible to expect such reports to be forthcoming unless required of the physician by specific legislation. The committee has supplied to the Council on Legislation for its consideration its comments on a rough draft of the proposed "Act to repeal R.S. 26:5-1 through 26:5-13."

The committee also considered a request for action on a recent regulation of the New Jersey Turnpike Authority barring trucks and busses from the innermost traffic lanes. We do not believe the committee should express an opinion about specific regulations, but should state our position as being in support of such regulations as the Turnpike Authority may issue in the interests of increasing safety on the turnpike by expediting smooth traffic flow. It seems clear that this may occasionally justify restrictions which work a hardship on some classes of turnpike users. We respect the advice of traffic-control experts employed by the Turnpike Authority, and we expect them to respect our judgment in regard to medical conditions which might produce driver limitation.

RECOMMENDATIONS

1. That the following principles for a program of driver limitation based on medical factors, as adopted by the AMA House of Delegates December 4, 1963, be adopted by the House of Delegates of The Medical Society of New Jersey:

a. Age per se should not be a limitation once the individual reaches licensing age; rather, the functional capacity and ability of each individual should be the determining factor.
b. Psychiatric disturbances are recognized as potential factors in accidents.
c. Acute and short-term disabilities should be recognized in relation to "driver limitation." In chronic illnesses, only uncompensated or intractable medical limitations are of concern to vehicle operation.
d. "Driver limitation" may be created by either a single major impairment or multiple minor impairments which collectively render the individual incapable of operating a motor vehicle safely.
e. The use of drugs and medications affecting the ability to drive results in "driver limitations" in some individuals.
f. Recipients of aid under various programs for the blind and individuals receiving Internal Revenue Service exemptions for visual loss should be considered automatically to be in the "driver limitation" group.

The following nine general areas are the most significant of the medical problems which must be evaluated to determine if "driver limitation" exists:

(1) Mental retardation below the ability to read.
(2) Uncompensated arthritic, skeletal, and amputation deformities likely to interfere with safe driving.
(3) Neurological defects; e.g. spastic defects, ataxia, paralysis agitans, intractable seizure states or blackouts, intractable narcolepsy.
(4) Cardiovascular defects; e.g. intractable Stokes-Adams syndrome, intractable angina pectoris, uncontrollable malignant hypertension, severe or intractable cardiac decompensation with dyspnea at rest, generalized and severe arteriosclerotic disease of incapacitating degree.
(5) Psychiatric problems; e.g. intractable psychoneurotic paranoid states; agitated depression.
(6) Obesity (gross and severe).
(7) Gross sensory deficits; e.g. severe impairments of corrected central visual acuity, severe reductions in visual fields, severe impairment of hearing.
(8) Chronic alcoholism and drug addiction.
(9) Other medical condition demanding individual analysis.

That a medical examination for "driver limitation" be conducted at least under the following conditions:

a. When a license applicant displays an obviously impaired physical function.
b. When a driver has been involved in multiple accidents within a short calendar period.
c. When a driver must be placed in the "assigned risk" pool for insurance underwriting because of refusal by various commercial insurance carriers to assume the risk.
d. When a driver voluntarily suggests that he "blacked out" or that medical problems contributed to an accident.

2. That copies of this report be transmitted to Messrs. Parsekian, Dauphers, and Schwoebel of the Division of Motor Vehicles; Mr. Harold Logan, Secretary of the Advisory Council to the New Jersey Consultation Service for Convulsive Disorders, and Dr. V. Terrell Davis, Director of the Division of Mental Health and Hospitals.

Amended to the extent that copies of this report will be sent to the respective departments with copies to the individuals named in the recommendation.
Approved as amended (page 334)

Miscellaneous . . .

NOMINATIONS FOR EMERITUS MEMBERSHIP

(Reference Committee "H")

The following nominations for election to emeritus membership at the 1964 annual meeting have been received from the component societies. Conforming to the provisions of Article IV, Section 6, of the Constitution, all nominees are now and have been members in good standing of a component society for at least twenty years, and by reason of age or infirmity have retired from the active practice of medicine. All are emeritus members of their respective component societies.

ATLANTIC COUNTY

James H. Mason, III, Atlantic City; Age 71
Daniel C. Reyner, Margate City; Age 70
Samuel E. Weiner, Atlantic City; Age 78

BERGEN COUNTY

Anthony M. DeSanto, Hackensack; Age 68
William M. Fliegel, Maywood; Age 65
Francis A. Macaulay, Teaneck; Age 66
Harry J. McLeod, Alpine; Age 64
Stuart W. Vanderbeek, Tenafly; Age 69

BURLINGTON COUNTY

William C. V. Wells, Belgrade Lake, Me. (formerly Delanco); Age 68

ESSEX COUNTY

Horace O. Bell, Newark; Age 69
F. Irving Ganot, Newark; Age 68
Edward P. J. Kearney, Montclair; Age 62
Robert E. Waldron, Murray Hill; Age 57
Edward H. Willan, East Orange; Age 69

GLOUCESTER COUNTY

Chester I. Ulmer, Woodbury; Age 76

HUDSON COUNTY

Joseph I. Berlin, Jersey City; Age 81
Howard R. Dukes, Short Hills; Age 74
Bernard S. Kelly, Jersey City; Age 74
Jacob L. Mathesheimer, Jersey City; Age 78
Harold F. Tidwell, Lake Worth, Fla. (formerly West New York); Age 72

MONMOUTH COUNTY

Harold A. Kazmann, Palo Alto, Cal. (formerly Long Branch); Age 68

PASSAIC COUNTY

Morris Joseph, Passaic; Age 75

UNION COUNTY

Charles S. Malatesta, Fort Lauderdale, Fla. (formerly Plainfield); Age 69

Approved (page 336)

SUPPLEMENTAL REPORT

The following additional nominations for election to Emeritus Membership at the 1964 annual meeting were received from:

ESSEX COUNTY

Margaret M. Wurts, Upper Montclair; Age 71

MERCER COUNTY

Harold S. Magee, Morrisville, Pa. (formerly Trenton); Age 70

Approved (page 336)

Relief of Widows and Orphans

At the annual meeting of The Society for the Relief of the Widows and Orphans of Medical Men of New Jersey, on April 28, 1964, the following officers were elected:

James E. D. Gardam, M. D. ..... President
Berthold T. D. Schwarz, M.D. .. Vice President
Joseph W. Gardam, M.D. ..... Secretary
George Fey Stoll, M.D. ..... Treasurer
Ogden B. Carter, Jr., M.D. ..... Asst. Treasurer
Herbert A. Schulte, M.D. ..... Custodian
G. N. J. Sommer, Jr., M.D. ..... Trustee
George A Delatush, M.D. ..... Trustee
J. R. Tobey, M.D. ..... Trustee

MEDICAL SERVICE ADMINISTRATION OF NEW JERSEY

Royal A. Schaaf, M.D., President, Board of Governors

(Reference Committee "C")

Medical Service Administration of New Jersey presents herewith its report for 1963 on the administration of the Medicare Program of the United States Government, and the City of Newark Medical Plan.

MEDICARE PROGRAM

Medical Service Administration of New Jersey in 1963 completed its seventh year as Fiscal Agent for The Medical Society of New Jersey in the administration of the physician's portion of the Medical Care Program for dependents of members of the armed services. Under this program, dependent spouses and children of persons in active military service qualify for medical, surgical, obstetrical, and hospital services rendered by civilian physicians and hospitals at the expense of the Federal Government.

MEDICARE CONTRACT

The Medicare contract under which Medical Service Administration operated expired June 30, 1963. Execution of a new contract was accomplished by Medical Service Administration of New Jersey, The Medical Society of New Jersey and the United States Government, Department of the Army, under date of July 1, 1963.

Subsequently, Medical Service Administration, as Fiscal Administrator, renewed the subcontract with Hospital Service Plan of New Jersey for the performance at cost of the administrative services under the Prime Contract, which services are being performed in the name of Medical Service Administration of New Jersey.

SCHEDULE OF ALLOWANCES

The Schedule of Allowances for services performed under the Medicare Program, which was negotiated with the Department of the Army by the Special Medicare Committee of The Medical Society of New Jersey, has remained unchanged since January 1, 1960. The fees are considered fair compensation for services rendered to patients with an annual income of $4,500.00, the average for members of the uniformed services.

PROVISION FOR ADJUSTMENT OF FEES

When, because of unusual procedures, a physician believes he is entitled to a fee in excess of that provided under the Schedule of Allowances, he may submit a Special Report to Medical Service Administration of New Jersey. Such a report is referred to the Special Medicare Committee of The Medical Society of New Jersey for review and recommendation.

The committee's recommendation is then forwarded to the Federal Government, which subsequently notifies Medical Service Administration of the amount to be paid the physician.

Practically without exception, the Office for Dependents' Medical Care has concurred in the recommendations of the committee.

PROVISION FOR MEDICAL CARE TO DEPENDENTS OF MEMBERS OF THE MILITARY FORCES OF NATO COUNTRIES

Effective July 1, 1963, the contract was amended to include the accompanying dependents of active duty military personnel, who are members of the land, sea, and air forces of North Atlantic Treaty Organization countries stationed in or passing through this country; these dependents are entitled to the same care under the Medicare Program as the dependents of members of the United States Uniformed Services.

STATISTICAL DATA

A statistical review of the Medicare Program in New Jersey since its inception in December 1956, is presented herewith:

CLAIMS EXPERIENCE

Period	Received	Declined	Returned Incomplete	Paid Claims	Paid Amount	On Hand
Dec. 7/56-Dec. 31/57	10,017	320	3,179	5,982	$ 489,265	356
Jan. 1/58-Dec. 31/58	14,014	377	3,758	9,298	778,551	1,082
*Jan. 1/59-Dec. 31/59	7,384	385	1,972	5,908	494,691	206
**Jan. 1/60-Dec. 31/60	7,925	197	2,384	4,930	413,687	610
Jan. 1/61-Dec. 31/61	7,241	244	1,921	5,681	466,848	5
Jan. 1/62-Dec. 31/62	9,508	361	2,140	6,133	510,844	906
Jan. 1/63-Dec. 31/63	7,759	322	1,182	6,508	536,354	653
TOTAL	63,848	2,206	16,536	44,440	$3,690,240	653

*Effective October 1, 1958, certain types of care were no longer authorized in civilian facilities

**Effective January 1, 1960, certain of the benefits curtailed in October 1958 were restored for Government coverage.

It will be noted that of the 7,759 physicians' claims received in 1963, 1,182, or more than 15% have had to be returned as incomplete or incorrect. Although the ratio of returned claims has decreased approximately 7% in 1963, the new Manual, or Handbook for Physicians, with its specific instructions concerning eligibility of dependents and services, should lessen the number of returned claims even more significantly.

1,898 physicians received payment in 1963 for services rendered under the Medicare Program.

ADMINISTRATIVE EXPENSES

Period	Amount	Cost per Case
Dec. 7/56-June 30/57	$ 19,670	11.44
July 1/57-June 30/58	28,796	3.21
July 1/58-June 30/59	31,983	3.77
July 1/59-June 30/60	17,383	3.74
July 1/60-June 30/61	17,448	3.39
July 1/61-June 30/62	17,240	2.94
July 1/62-June 30/63	20,547	3.00
	$153,067	

The above administrative expense data reflect the initial costs accrued in promulgating the program in New Jersey (contract negotiations, printing, distribution of manuals, training), and the subsequent additional costs in connection with printing and distribution of new manuals and schedules of allowances.

MEDICARE MANUAL FOR PHYSICIANS AND DENTISTS

On November 22, 1963, a Manual for Physicians and Dentists Providing Civilian Care to Dependents of the United States Uniformed Services, popularly known as the "Medicare Program," was distributed to the physicians of New Jersey.

This Manual was prepared by the United States Government and is concerned primarily with administrative instructions in regard to authorized services and eligibility of dependents.

The information contained in this Manual should aid considerably in preparing Medicare claim Forms DA 1863-2 for processing and adjudication, thereby reducing the number of claim forms returned to physicians as "incomplete."

CHANGE OF FISCAL ADMINISTRATOR FOR PHYSICIANS' CLAIMS

Due to continuing losses of operation and the small surplus held by Medical Service Administration of New Jersey, which had been designated as Fiscal Administrator by The Medical Society of New Jersey since the inception of the Medicare Program, the Government suggested a change of Fiscal Agent for the Medicare Program in New Jersey.

As Prime Contractor to the Government, The Medical Society of New Jersey, at a meeting of its Board of Trustees on July 21, 1963, took action to designate Medical-Surgical Plan of New Jersey (Blue Shield) as its Fiscal Administrator to replace Medical Service Administration of New Jersey for the contract year beginning July 1, 1964 and ending June 30, 1965.

At meetings held by the Board of Governors of Medical Service Administration of New Jersey, and by the Board of Trustees of Medical-Surgical Plan of New Jersey on September

24, 1963, the actions of both Boards concurred in the action taken by the Board of Trustees of The Medical Society of New Jersey on July 21, 1963.

In consequence of the foregoing actions, the Agreement between Medical Service Administration of New Jersey and the Hospital Service Plan of New Jersey (Blue Cross), whereby certain administrative services described in a subcontract between both organizations are being performed by Hospital Service Plan, will terminate on June 30, 1964 without renewal.

Hence, beginning with July 1, 1964, all physicians' Medicare DA 1863-2 Claim Forms will be submitted to Medical-Surgical Plan of New Jersey (Blue Shield) for processing and payment.

CITY OF NEWARK MEDICAL PLAN

Thirty physicians participated during 1963 in the City of Newark Medical Plan which provides for medical services rendered in the homes of indigent and medically indigent persons by physicians of the patient's choice on a fee-for-service basis; where a patient has no family physician, a telephone call to the Newark Division of Health will bring a physician to the home.

The classification of *indigent* is applied to those persons whose names appear on the Welfare Rolls of the City of Newark; the *medically indigent* are those who are considered by the City Division of Health as having income sufficient to meet the necessities of an adequate standard of living, but insufficient to pay for needed medical care.

The problem of reaching physicians for weekend or night calls received the helpful attention of the Essex County Medical Society.

At this writing, a Special Committee of the Essex County Medical Society is making an active study of the Newark care of the medically indigent program, with recommendations for increased fees to compare with those paid by the Essex County Welfare Board. For this, our sincere appreciation and gratitude.

Approved services rendered from January 1 to December 31, 1963, as compared with former years, were:

RELIEF					
Year	1959	1960	1961	1962	1963
Number of cases	2154	1654	1484	1151	1149
Value of Services	$10,791	$7,417	$6,914	$5,329	$5,339
MEDICALLY INDIGENT					
Number of cases	3425	2553	1732	1252	1189
Value of Services	$16,439	$11,979	$8,197	$5,999	$5,587

In 1963, Medical Service Administration received from the City of Newark $12,018.60 for services rendered from November 1962 through October 1963; allocated as follows:

	For Physicians' Fees	*Plus 10% Service Charge*	*Representing Number of Visits*
Division of Welfare (Relief)	$ 5,339.00	$ 533.90	1,149
Division of Health (Med. Ind.)	5,587.00	558.70	1,189
	$10,926.00	$1,092.60	2,338

Medical Service Administration of New Jersey is justly proud of its record as Fiscal Administrator for the City of Newark and for the Federal Government in the administration of the City of Newark Medical Plan and the Medicare Program. We have endeavored to serve conscientiously, and we believe that we have successfully conducted the programs assigned to us.

Approved (page 327)

MEDICAL-SURGICAL PLAN OF NEW JERSEY

Nicholas F. Alfano, M.D., President, Newark

(Reference Committee "C")

The year of 1963 saw continued growth in Medical-Surgical Plan's service to the New Jersey community, manifest in all areas of the Plan's operations despite impediments that were encountered during the year. That the Plan was able to gain as it did in the face of adversities offers assurance that it will continue to grow in service and stature . . . in spite of problems still remaining in its path, and new ones which have already cast their shadows before them.

Most heartening was the continuing vote of confidence given by the people of New Jersey through increased enrollment in the Plan. During the year membership of subscribers and their dependents increased by over 128,000, bringing the total at year's end to more than 2,450,000 persons. As the result of this progress, Medical-Surgical Plan moved up to fifth in size of all Blue Shield Plans . . . only a year after advancing from seventh to sixth in size.

Benefits paid on behalf of subscribers set a new record, with incurred claims of nearly $41 million, an increase over the preceding year of more than $3 million. Substantial gains also were registered in the number of cases paid and the number of medical and surgical services paid for.

Although underwriting operations for the year showed a substantial loss, income from investments and adjustments in reserves enabled the Plan to register a slight gain in reserves for 1963. The reserve margin remains rather precarious, however, since at year's end it represented only 1.5 months of average claims and operating expense.

Flexibility in adapting to changing needs in health care protection was demonstrated in new programs especially designed for two large groups, New Jersey Bell Telephone Co. and Western Electric Co., Inc. The ability to meet special needs in various segments of industry grows increasingly important to the Plan's continued growth, if not its survival . . . and in connection with this it is interesting to note that in addition to the two groups mentioned, special programs are now being administered for Federal Employees, State of New Jersey Employees, groups within the Motors Industry and the Steel Industry, Senior Citizens and College Students.

The Plan's ability to adapt, however, remains blocked in one important area . . . entering into national account agreements with other Blue Shield Plans that would enable Medical-Surgical Plan to serve New Jersey employees of companies that also have operations in other states, and desire uniform Blue Shield coverage for all their employees. Medical-Surgical Plan of New Jersey is the only Blue Shield Plan in the country lacking legal authority to do this, an impediment recognized in the recent study made by a bi-partisan Legislative Commission . . . which resulted in the introduction of legislation to correct the situation. Unfortunately, commercial insurance interests and other organized factions have been successful in blocking passage of this much-needed legislation in 1963, and up to the time of this writing in 1964.

A decision by the New Jersey Supreme Court holding unconstitutional a portion of the Plan's Enabling Act . . . which requires approval of the Plan's Trustees by The Medical Society of New Jersey . . . did not impair in any practical degree the close and harmonious relationship that has existed between the two organizations since the Society founded the Plan in 1942. The court's decision on the constitutionality of another portion of the Enabling Act . . . the requirement that at least 51 per cent of the eligible physicians in a New Jersey County must participate, in order for the Plan to do business in that county . . . is still forthcoming at this writing. We are confident that, no mat-

ter what the Court may decide, participation in Blue Shield will continue to stem from the physician's belief in the voluntary prepayment principle as the true expression of the free enterprise system, and from his desire to help Blue Shield in assisting the less affluent members of society to afford the world's finest medical care. We do not believe that physicians participate in Blue Shield because of a legal requirement placed upon the Plan . . . and should it be removed, we will look to continuing and increased participation, toward which we will bend every effort.

Of material assistance in conserving resources of both Blue Shield and Blue Cross, through painstaking review of disputed claims, was the Special Committee of the Medical Society appointed for that purpose. The Plan is grateful to the Committee members for their work, and to the Society for providing a mechanism which assures a physician that his disagreement with the Plans will receive, in anonymity, a full impartial hearing from an eminent jury of his peers.

Other developments of the year that are worthy of note include the Board of Trustees decision, along with a similar decision by Hospital Service Plan, to make Rider J available to non-group members; consideration is being given to scheduling the most advantageous time for making this offering. The Plan also is gratified that the Medical Society saw fit to designate it as fiscal administrator for the Medicare program.

A report on 1963 would not be complete without mention of an adversity that nevertheless brought its compensations. A strike of more than three weeks duration by the unionized clerical employees of Medical-Surgical Plan and Hospital Service Plan crippled Plan operations, and would have halted them completely, except for the extraordinary efforts of the management employees. The patience and understanding exhibited by physicians during those trying times made the Plan's difficulties easier to bear, and contributed in good measure to the dedication exhibited by the management staff. The ongoing support and cooperation of the Plan's Participating Physicians and The Medical Society of New Jersey will continue to evoke this dedication by our operating staff in serving our members and the medical profession.

FEDERAL EMPLOYEE PROGRAM

The Plan has participated in the underwriting of the Government-Wide Service Benefit Program for Federal Employees since its inception in July, 1960, and now has over 100,000 Federal Employees enrolled.

In 1963, subscribers covered under the Federal Program received improvements in Blue Shield coverage, without a corresponding increase in rates. In-hospital days of medical care for nervous and mental disorders and pulmonary tuberculosis were increased from 30 to 120 days per admission under the High Option Program, and from 10 to 30 days under Low Option. A new added benefit was coverage of 10 days of intensive in-hospital medical care, under High Option.

Additional broadening of benefits included coverage of laboratory services and diagnostic x-rays performed in the out-patient department or doctor's office in connection with minor surgery for non-accidental conditions.

During 1963 the Plan paid over 26,000 cases under the Federal Employee Program. The following is the statement of income and expense:

Income	$1,922,658	100.0%
Claims Incurred	1,823,399	94.8
	$ 99,259	5.2%
Operating Expense	77,516	4.0%
Gain	$ 21,743	1.2%

PAID BASIS

Average Exposure (Persons)	111,174
Claim Incidence per 1,000	
Persons Enrolled	241
Average Cost per Case	$65.40
Number of Cases	26,797
Amount Paid	$1,752,399

PUBLIC RELATIONS PROGRAM

Public Relations during 1963 continued to move successfully toward the broad objectives

of achieving for Medical-Surgical Plan better understanding and appreciation . . . among subscribers, physicians and the general public . . . together with improved recognition of the Plan's identity. This was accomplished through all media at the Plan's command, including newspapers, specialty publications, literature, correspondence, radio, billboards, posters, Plan publications, and personal contacts.

Of noteworthy success was a project carried out in collaboration with the Public Relations Chairman, which turned an adverse public relations situation to good account for the Plan.

The problem arose from publication in the press of misrepresentations, concerning the Plan made by two physicians. To refute their charges, the Public Relations Officer and Public Relations Chairman collaborated on a detailed presentation, which the chairman made at the Open Discussion on Medical-Surgical Plan during the Annual Meeting of The Medical Society of New Jersey.

The published mis-statements were effectively rebutted with the aid of graphic displays showing comparisons of Plan fees with "going rates" for various services, changes in Plan fees from 1945 to 1963, and photostatic enlargements of Plan literature, advertisements and other printed material in which the Service Benefits provisions were spelled out.

As a follow-up, the Plan sent reprints of the account published in THE JOURNAL of The Medical Society of New Jersey to all physicians in the state. Medical Economics Magazine prepared an abridged version of the proceedings, which the Public Relations Officer assisted in editing prior to its publication in the magazine. The combined result cleared the air, and accomplished better understanding and appreciation of the Plan.

News releases on Plan activities, growth and progress continued to be a major vehicle for projecting and protecting a favorable concept of Blue Shield. In this way the public was kept informed of the Plan's advance to fifth largest of all Blue Shield Plans; new highs in benefits extended and services covered; reopening of special programs for Senior Citizens and Students, and other matters reflecting favorably on the Plan. The advertising campaign carried on jointly with Hospital Service Plan provided another effective means of keeping the value of Blue Shield before the public, through a variety of media.

The special "publics" with which the Plan is most intimately concerned . . . subscribers and physicians . . . additionally were reached through further channels of communications. The Public Relations Office supervised, and in many cases generated, the content of virtually all non-technical printed material issued by the Plan, and the Medical-Surgical Plan content of joint Blue Cross-Blue Shield printed material, including brochures, leaflets, fliers, forms, form letters, mass mailings, posters, special reports, etc., along with handling a large volume of direct correspondence with individuals and other Plans on Medical-Surgical Plan policies, procedures and benefits. The compilation and editing of "Blue Shield Pulse," and participation with Hospital Service Plan in the editorial supervision and writing of "Fast Facts" and "Two Blues News," provided further avenues for effectively reaching physicians, opinion molders and Plan employees.

While the complexity and scope of problems involving public relations are increasing, there is every reason to be confident that they will continue to be met effectively, with the fine support demonstrated by the Board of Trustees, its Public Relations Committee, and the Plan's Officers and staff.

CLAIMS INCURRED

Year	Amount
1963	$40,991,000
1962	37,753,000
1961	34,575,000
1960	31,516,000
1957	22,886,000
1954	13,992,000
1951	6,527,000
1948	1,204,000
1945	208,000
1942	5,000

Comparative Balance Sheet December 31, 1963

Assets		*Dec. 31, 1963*		*Dec. 31, 1962*
1. Cash on Hand and in Banks (Working Funds)		$ 549,108		$ 612,316
2. Investments		13,369,911		12,033,098
Accounts Receivable:				
3. Subscriptions		729,898		874,707
4. Workmen's Compensation		36,332		41,055
5. Federal Employee Program		562,238		437,113
6. Miscellaneous		2,134		685
7. Accrued Interest and Dividends Receivable		121,862		101,071
Total Assets		$15,371,483		$14,100,045
Liabilities				
1. Claims Outstanding:				
2. Reported	$2,420,000		$1,795,000	
3. Unreported	4,570,000	$ 6,990,000	4,855,000	$6,650,000
4. Unearned Subscriptions		2,082,560		1,572,876
5. Accounts Payable— Hospital Service Plan		485,619		336,265
6. Accounts Payable— Miscellaneous		193,482		178,735
Total Liabilities		$ 9,751,661		$ 8,737,876

TABLE II

Distribution of Rider Services and Payment

	Total Services	*% All Services*	*Payment Amount*	*Payment Percent*	*Payment Per Service*
Surgical	9,076	19.2%	$ 196,581	20.3%	$ 21.66
Medical	1,939	4.1	114,442	11.8	59.02
Diag. X-Ray	20,415	43.3	422,561	43.7	20.70
X-Ray Therapy	286	0.6	33,004	3.4	115.40
Physical Therapy	1,703	3.6	42,983	4.4	25.24
Pathology	13,766	29.2	158,891	16.4	11.54
Total	47,185	100.0%	$ 968,462	100.0%	$ 20.52

TABLE III

Distribution of Earned Subscription Income		
Earned Subscription Income	$44,613,365	100.0%
Incurred Claims	40,990,924	91.9
Operating Expense	3,950,841	8.8
Underwriting Loss	328,400	.7

Distribution Per Dollar of Income

Surgical	46.5
Medical	21.0
Obstetrical	15.4
Anesthesia	7.4
Consultations	1.6
Operating Expense	8.8
Underwriting Loss	0.7

Reserves		
1. Securities Evaluation	$ 400,000	$ 361,000
2. Special Contingent	100,000	100,000
3. Unassigned	5,119,882	4,901,169
Total Reserves	$ 5,619,882	$ 5,362,169
Total Liabilities and Reserves	$15,371,483	$14,100,045

Annual Statistics 1963

TABLE I

Paid 1963	*Total Services*	*% All Services*	*Payment*	*Percent*	*Payment Per Service*
Surgical	329,166	46.5%	$19,821,565	50.7%	$ 60.22
Medical	162,944	23.0	8,931,546	22.8	54.81
Obstetrical	47,143	6.6	6,548,632	16.8	138.91
Consultations	43,805	6.2	678,977	1.7	15.50
Anesthesia	125,548	17.7	3,138,020	8.0	24.99
Total	708,606	100.0%	$39,118,740	100.0%	$ 55.21

Table I excludes Federal Claims Data

NEW JERSEY PARTICIPATING AND NON-PARTICIPATING PHYSICIANS BY COUNTY

	County	Total Eligible Phys.	Participating Total	Participating M.D.	Participating D.O.	Participating D.S.C.	Non-Participating Total	Non-Participating M.D.	Non-Participating D.O.	Non-Participating D.S.C.	% P. P. as of 12/31/63	% P. P. as of 12/31/62
1	Atlantic	217	200	169	18	13	17	17			92.1	92.8
2	Bergen	998	644	557	50	37	354	334	17	3	64.5	66.7
3	Burlington	204	181	147	25	9	23	19	4		88.7	88.3
4	Camden	562	486	346	111	29	76	71	3	2	86.5	87.1
5	Cape May	71	65	53	10	2	6	4	2		91.5	91.1
6	Cumberland	118	115	105	4	6	3	2	1		97.4	97.4
7	Essex	1666	1337	1222	46	69	329	315	12	2	80.2	81.0
8	Gloucester	125	107	76	22	9	18	14	4		85.6	84.8
9	Hudson	711	571	525	10	36	140	136	2	2	80.3	82.1
10	Hunterdon	63	60	59	1		3	3			95.2	95.4
11	Mercer	452	369	344	10	15	83	77	6		81.6	81.7
12	Middlesex	393	309	280	13	16	84	82	1	1	78.6	79.5
13	Monmouth	422	329	297	16	16	93	90	3		77.9	80.3
14	Morris	336	277	251	17	9	59	53	5	1	82.4	82.8
15	Ocean	125	100	92	5	3	25	25			80.0	80.8
16	Passaic	614	460	408	17	35	154	149	3	2	74.9	75.5
17	Salem	47	46	39	5	2	1	1			97.8	94.1
18	Somerset	142	116	109	4	3	26	26			81.6	79.7
19	Sussex	49	45	39	4	2	4	4			91.8	89.5
20	Union	748	543	471	35	37	205	199	5	1	72.6	72.7
21	Warren	49	47	45	2		2	2			95.9	95.7
22	Out of State	288	278	247	30	1	10	10			96.5	96.0
	TOTALS	8400	6685	5881	455	349	1715	1633	68	14	79.5	80.3

COMPARATIVE SUMMARY OF OPERATIONS

	1963			1962	
Subscriptions Earned*	$44,613,365	100.0%		$41,380,643	100.0%
Less:					
Claims Incurred $40,990,924**		91.9	$37,752,559		91.2
Operating Expenses 3,950,841***		8.8	3,695,125		8.9
	44,941,765	100.7		41,447,684	100.1
(Loss) from Underwriting Operations ..	(328,400)	(.7%)		(67,041)	(.1%)
Income on Investments	434,277			383,981	
Operating Gain for the Year	$ 105,877			$ 316,940	

* The gain of $3,232,722 in subscriptions earned (not including Federal Employee Contracts) reflects gains in enrollment, which increased by 128,603 during the year.

** The rise of $3,238,365 in claims incurred is attributable to increased exposure from larger enrollment and to increased incidence, which rose from 179 per 1,000 persons to 193.

*** The increase of $255,716 in operating expenses is caused by increased services rendered by Hospital Service Plan in the amount of $210,062 and a rise of $45,654 in Medical-Surgical Plan direct expenses. Based on subscriptions earned, total operating expense decreased by one tenth of one percent.

SUMMARY OF RESERVES FOR PROTECTION OF SUBSCRIBERS

Reserves at January 1		$5,362,169		$5,233,189
Operating Gain for the Year		105,877		316,940
		5,468,046		5,550,129
Plus:				
Reserve Adjustments				
Non-Admitted Assets	$ 81,016		$(1,096)	
Unrealized Capital Gains	47,760		13,136	
Claim Reserve	(200,000)		(200,000)	
Rider "J" Income	223,000			
		151,776		(187,960)
		$5,619,822*		$5,362,169

* The increase of $257,653 in reserves for the protection of Plan Subscribers is caused by a net operating gain of $105,877 and an increase in reserve adjustments totaling $151,776.

INCIDENCE RATE PER 1,000 PERSONS ENROLLED

Year	Incidence
1963	193
1962	182
1961	177
1960	166
1956	143
1954	126
1951	112
1948	96
1945	86
1942	40

PHYSICIAN RELATIONS PROGRAM

During 1963, the Physician Relations Section maintained its objective of liaison and cooperation between the Plan and its thousands of Participating Physicians. This objective was accomplished through many avenues of communication, including: maintainance of information desks in the physicians' lounge of forty-two hospitals; addressing physicians at medical staff meetings in thirty-seven hospitals; personal visits to the offices of one hundred and thirty-eight physicians; manning Plan exhibits at several medical conventions, and attendance at many other miscellaneous meetings, including those of county medical societies, specialty societies and medical assistants.

The primary purpose of this field program is to explain Plan policy; advise physicians of such matters as changes in the Schedule of Maximum Plan Payments, issuance of new contracts and riders with broader benefits, and manner of payment for specific services; and to resolve any problems the physician and/or his medical assistant is encountering in his dealings with the Plan.

In office, the Physician Relations Section performed many additional duties which contributed to effective liaison between the Plan and its Participating Physicians. Hundreds of problem cases involving physicians and subscribers were resolved, in the course of which thousands of telephone calls and hundreds of written communications were handled. The Section also prepared, proofread and distributed fee schedule revisions and Newsletters to physicians. The Section also maintained the physician status files, making daily additions, deletions, address changes, participating status, etc., and prepared and proofread the listing of Participating Physicians distributed to thousands of subscribers throughout the state.

It is our belief that each facet of this program has effectively projected the image of Blue Shield to the medical profession. Our task has been made easier by the genuine interest and cooperation shown by individual physicians during the course of the many thousands of personal contacts made during the past year.

We are "selling" an intangible item . . . good will. Since our contacts are to a large degree personal, the results can only be measured by our individual perception of greater warmth, cooperation and reliance upon our services by the medical profession. The work of Physician Relations is never ending. If we become satisfied with our results, we are finished.

In the coming year, every effort will be made to effectively maintain and enhance this "two way" street of communication between the Plan and the medical profession.

Recommendation adopted by the House that each component society reactivate or establish the advisory committee to the Medical-Surgical Plan for development of better Physician-Plan understanding and to encourage increased physician participation in the plan. (page 327)

ENROLLMENT GROWTH

Year	Enrollment
1963	2,450,755
1961	2,176,679
1958	1,830,397
1954	1,196,804
1951	669,906
1948	236,604
1945	49,441
1942	4,131

1963 BOARD OF TRUSTEES

Chairman of the Board
Royal A. Schaaf, M.D. (1965)
First Vice President
Thomas J. White, M.D. (1965)
Second Vice President
Rudolph C. Schretzmann, M.D. (1965)
Secretary-Treasurer
John S. Thompson (1965)

MEMBERS

Charles W. Barkhorn, M.D.	(1966)
Irving P. Borsher, M.D.	(1966)
Robert G. Boyd	(1966)
Charles L. Cunniff, M.D.	(1966)
Andrew P. Dedick, Jr., M.D.	(1966)
Joseph P. Donnelly, M.D.	(1964)
Joseph I. Echikson, M.D.	(1964)
Jerome G. Kaufman, M.D.	(1964)
Joseph M. Keating, M.D.	(1964)
Elton W. Lance, M.D.	(1964)
Samuel J. Lloyd, M.D.	(1964)
Jesse McCall, M.D.	(1964)
Duane E. Minard, Jr.	(1965)
Sidney I. Simon, Ph.D.	(1966)
Edward W. Sprague, M.D.	(1965)
Charles O. Tyler, M.D.	(1965)
Robert E. Verdon, M.D.	(1966)
Gustave E. Wiedenmayer	(1966)

FORMER MEMBERS OF THE BOARD OF TRUSTEES

David B. Allman, M.D.	1945-1945
*Theophilus H. Boysen, M.D.	1944-1945
Lewis W. Brown, M.D.	1949-1954
*William J. Carrington, M.D.	1942-1943
*Patrick H. Corrigan, M.D.	1952-1958
*Samuel A. Cosgrove, M.D.	1944-1953
William K. Harryman, M.D.	1944-1945
Sigurd W. Johnsen, M.D.	1950-1951
*Augustus S. Knight, M.D.	1942-1948
*Thomas K. Lewis, M.D.	1942-1949
Paul Mecray, Jr., M.D.	1953-1961
Glennis S. Rickert, M.D.	1959-1963
*Norman M. Scott, M.D.	1942-1950
Reuben L. Sharp, M.D.	1950-1951
James J. Spencer, M.D.	1957-1961
*Carl K. Withers	1952-1961
David L. Yunich	1962-1963

* Deceased

OFFICERS

Nicholas F. Alfano, M.D.
President and Medical Director

John S. Robinson
Executive Vice President

John S. Thompson
Secretary-Treasurer

ADVISORS TO THE BOARD OF TRUSTEES

	Appointed	*Term as Board Member*
F. Clyde Bowers, M.D.	1963	1961-1963
Harry N. Comando, M.D.	1959	1942-1958
William F. Costello, M.D.	1958	1948-1958
William E. Dodd, M.D.	1952	1944-1952
Arthur W. Lunn	1962	1951-1962

Approved (poge 327). House colled ottention of members of component societies to the importonce of their giving full cooperation in filling out questionnaires for the Test Performonce Survey presently being conducted by Medical-Surgical Plan of New Jersey as part of a national survey.

ABOUT NEXT YEAR'S MEETING

The 199th Annual Meeting of The Medical Society of New Jersey will be held from May 15 through May 19, 1965, at Haddon Hall, Atlantic City.

Applications for space in the scientific exhibits will be accepted up to, and including, December 18, 1964. Notification of the committee's action will be made soon thereafter.

Members are cordially invited to apply for space in the scientific exhibits at the 1965 Annual Meeting. Register your name to receive an application form by contacting the Executive Officers of MSNJ, P. O. Box 904, Trenton, New Jersey 08605.

The Committee on Scientific Program invites members to submit titles and brief abstracts of scientific papers they wish to present at the 1965 Annual Meeting. Categories of the scientific sections are as follows: allergy, anesthesiology, cardiovascular diseases, chest diseases, clinical pathology, dermatology, gastroenterology, and proctology, general practice, medicine, metabolism, obstetrics and gynecology, ophthalmology, orthopedic surgery, otolaryngology, pediatrics, psychiatry and neurology, radiology, rheumatism, surgery, urology.

Send to the Executive Offices—by August 28, 1964—your name, address, title, and brief abstract, and indicate the appropriate session for your paper.

RESOLUTIONS

1

DRUG ADDICTION PROBLEMS

From the Middlesex County Medical Society

(Reference Committee "G")

Whereas, the Middlesex County Medical Society has been actively engaged in the study of the drug addiction problem in teenagers, and

Whereas, we feel the problem is of great importance at the present time and will be more of a threat in the future; now therefore be it

RESOLVED, (1) That The Medical Society of New Jersey engage in a state-wide education program to prevent drug addiction in conjunction with our law enforcement agencies; and

(2) That Medical Society representatives meet with the Narcotics Advisory Committee to formulate proper procedures for the treatment and follow-up care of addicts; and

(3) That the Medical Society of New Jersey join and encourage the State Legislature in demanding more stringent laws concerning the imprisonment of people involved in the illegal sales of narcotics and drugs.

Approved (page 334)

2

PRE-EMPLOYMENT PHYSICAL EXAMINATIONS

From the Sussex County Medical Society

(Reference Committee "E")

Whereas, in practical aspects, there is a lack of consistency in the methods of remuneration to physicians who examine minors under 18 for working papers, and

Amended to read: "Whereas, there is at present o lack of consistency in the methods of choice of physicians to exomine minors under 18 for working popers; ond"

Whereas, the principles of free choice of physician and of fee for service are the accepted, customary methods of medical practice, and

Whereas, the recipient of a service should always have a moral responsibility in the payment for a service, and **(This porogroph deleted)**

Whereas, the school system must always have the ultimate control and responsibility in supervising scholastic performance; now therefore be it

RESOLVED, (1) That pre-employment physical examinations should be performed by freely chosen physicians, rather than designated physicians; and

Amended to read: "RESOLVED: (1) that pre-employment physicol exominotions should be performed by either freely chosen or designoted physicions; ond"

(2) That payment to the physician should be made directly by the applicant or in a deferred manner based on payroll deduction—the period of deferred payment not to exceed six (6) weeks; and **(This porogroph deleted)**

(3) That each physician shall notify the office of the respective school superintendent, the name of each applicant and the date of each examination on a properly designed post card; and **(This porogroph deleted)**

(4) That The Medical Society of New Jersey develop and actively support the passage of amendments to existing legislation, necessary for accomplishment of the above ends.

Amended to become RESOLVED porogroph (2)
Approved os omended (poge 330)

3

RIGHTS OF PHYSICIANS IN HOSPITALS

From the Union County Medical Society

(Reference Committee "F")

Whereas, the medical profession of the United States of America has need of a status in hospitals based on democratic principles, and

Whereas, the democratic right of free election of staff officers, the recall of elected officers, and the right to formulate staff by-laws have been denied physicians, and

Whereas, the democratic rights physicians must have include:

(1) The right of the active medical staff, or other broadly-based segment of the medical staff, to elect the officers and chief of departments and divisions of the medical staff of the hospital;

(2) The right of the active medical staff, or other broadly-based segment of the medical staff, to review and revoke the actions or elections of officers, Executive Committee, or medical staff physicians;

(3) The right of the active medical staff, or other broadly-based segment of the medical staff, to formulate and to revise the By-Laws and Rules and Regulations of the medical staff; and

Whereas, this "Bill of Rights" for the physicians of the United States of America is included in the Special Memorandum, dated June, 1963, of The Medical Society of New Jersey—and as amended October, 1963, by the Subcommittee of the Council on Medical Services—and is titled "Proposed Guides for Physician-Hospital Relationships in New Jersey"; now therefore be it

RESOLVED, that the Union County Medical Society approve and endorse these Guides as a statement of principles which we will actively support; and be it further

RESOLVED, that this resolution be presented to the House of Delegates at the 198th Annual Meeting of The Medical Society of New Jersey, May 16-20, 1964, to be held in Atlantic City, New Jersey; and be it finally

RESOLVED, that the Delegates to the American Medical Association present this resolution to the House of Delegates at the Annual Meeting, June 21-25, 1964, in San Francisco, California.

Accepted and approved (page 332), with the notation that the terms (1) "active medical staff" and (2) "other broadly-based segment of the medical staff" are not herein defined; their definition should be left to the medical staff of the respective hospitals.

House directed that copy be sent to the president and secretary of all medical staffs, hospital administrators, and hospital lay boards in New Jersey (page 332).

4

AREA-WIDE PLANNING FOR HOSPITALS

From Paul J. Kreutz, M.D., Delegate from Union County

(Reference Committee "F")

Whereas, the United States Public Health Service in collaboration with the American Hospital Association, has conducted a survey and issued a joint report on "Area-Wide Planning for Hospital," and

Whereas, this report, as well as burgeoning literature on the subject, presents the thesis that only the big voluntary non-profit or government hospital can render complete or the best medical service, and

Whereas, this joint report also advanced the seductive argument that the building of private-for-profit hospitals may deprive a community of an "opportunity" to obtain government funds for a non-profit institution, and

Whereas, these reports encourage compulsory area-wide planning for hospitals and other health facilities to be implemented by legalized state agencies, and

Whereas, the National President of Blue Cross, Mr. Walter J. McNerney, has been quoted as stating "any group which builds without reference to community planning jeopardizes the solvency of Blue Cross," and

Whereas, in one area Blue Cross tried to deny claims from a hospital which had expanded its plant without consulting its area planning board, and

Whereas, federal money is now being used for state-wide surveys for area-wide planning for health facilities in Minnesota, Kansas, and Hawaii, and

Whereas, efforts are being made in various states to establish compulsory area-wide health facilities planning on a statutory basis, and

Whereas, S-855 by Senator Hubert Humphrey, which passed the Senate in January ('64) without debate, affords federal recognition and commendation for all such planning boards and commissions and lays the ground work for ultimate complete control by such boards; now therefore be it

RESOLVED, that the House of Delegates of The Medical Society of New Jersey oppose compulsory area-wide planning for health facilities and urge the membership to join in this opposition; and be it further

RESOLVED, that the House of Delegates of the Medical Society oppose S-855 and similar legislation which would virtually federalize compulsory area-wide planning; and be it finally

RESOLVED, that the Delegates of The Medical Society of New Jersey to the American Medical Association be instructed to support similar resolutions at the Annual Meeting of the American Medical Association in June, 1964.

Considered with #7.

Disapproved (page 331) because:

1. The committee is in favor of VOLUNTARY area planning without governmental interference.
2. The committee is in favor of VOLUNTARY area planning on a local level.
3. The committee is in favor of a positive approach to this problem as set forth in Resolution #7.
4. The committee is opposed to a negative approach to this problem as set forth in Resolution #4.

5

PROPOSED AMENDMENT TO BYLAWS

From the Burlington County Medical Society

(Reference Committee on Constitution and Bylaws)

Whereas, rising costs of operation have, from time to time, necessitated an increase in the assessment of the active members of The Medical Society of New Jersey, and

Whereas, the rights and privileges of an associate member are the same as an active member except for the right to hold office and the right to vote (which vote is really only 1/20 of a vote at the State Society level), and

Whereas, the associate members have the same privileges of insurance, hospitalization, and all other privileges accorded to active members; now therefore be it

RESOLVED, that Chapter XI, Section 4, paragraph (c) of the Bylaws of The Medical Society of New Jersey be changed to read:

(c) Associate members shall be assessed two-thirds (2/3) of the current per capita assessment.

Approved (page 324)

6

IMPLEMENTATION OF AMA RESOLUTION #68

From the Essex County Medical Society

(Reference Committee "D")

Whereas, the American Medical Association at its Annual Convention took additional recognition of the "importance of the general practitioner as an essential component of American medicine," and

Whereas, once again cognizance was taken of the need for "an adequate number of medical school graduates selecting general practice for their medical careers," and

Whereas, the AMA House of Delegates did resolve to instruct its Board of Trustees to utilize all facilities at its command to:

(1) Inform the medical schools of the shortage of general practitioners, and request their cooperation in exposing medical students to general practice by lectures, preceptor programs, and clinical instructors who are practicing general practitioners, and

(2) Inform the constituent state medical societies of the need to emphasize general practice training and to ask these societies' members to encourage students to go into general practice; now therefore be it

RESOLVED, that The Medical Society of New Jersey House of Delegates likewise take cognizance of this problem and instruct the Board of Trustees to utilize all facilities at its command with deliberate speed to implement the intent of Resolution #68 passed by the AMA House of Delegates; and be it further

RESOLVED, that the Board of Trustees of The Medical Society of New Jersey report back to the 1965 House of Delegates what actions have been taken in the State of New Jersey and what progress has been made in solution of this serious problem facing the American public, namely, the impending critical shortage of general practitioners to serve the public.

Adapted (page 328)

7

AREA-WIDE PLANNING FOR HOSPITALS

From the Essex County Medical Society

(Reference Committee "F")

Following paragraph inserted by House:

"Whereas, The Medical Society of New Jersey recognizes the urgent need for long-range planning with respect to future hospital construction and future expansion of existing health facilities with the objective of stemming the rising cost of hospital care and to provide better and more comprehensive medical care to all of our population; and"

Whereas, area-wide planning is coming more and more under federal control through the lever of Hill Burton funds, and

Whereas, published reports indicate that certain groups are attempting to enact enabling legislation in each State to empower the State Department of Health or other agency to act as judge of the need for new hospital beds, and

Whereas, such area-wide planning will continue to have a major impact on the private practice of medicine, and

Whereas, The Medical Society of New Jersey stands willing to cooperate in any voluntary effort to improve health care for the citizens of New Jersey; now therefore be it

RESOLVED, that The Medical Society of New Jersey express its opposition to any attempt to pass enabling legislation making

recommendations of planning councils compulsory, at either the State or Regional level; and be it further

RESOLVED, that The Medical Society of New Jersey recommend that voluntary hospital planning councils and their sub-committees contain physicians who are actively engaged in the private practice of medicine with representation equal to the representation from any other group, and that the physician representation be approved by the medical society representing the geographic area involved; and be it further

Fallawing paragraphs inserted by Hause:

"RESOLVED, that The Medical Saciety af New Jersey participate an valuntary health facilities planning cauncils whase purpases are cansanant with the abjectives expressed in the initial paragraph; and be it further

"RESOLVED, that The Medical Saciety of New Jersey initiate activity at the cammunity and municipal levels to develop lacal health facilities planning cauncils, upan which adequate representatian of interested graups is pravided far—the medical representatian ta be appraved by the medical saciety representing the geagraphical area invalved."

Considered with #4.

Approved as amended by the Hause (page 331), because:

1. The cammittee is in favar af VOLUNTARY area planning withaut gavernmental interference.
2. The cammittee is in favar af VOLUNTARY area planning an a lacal level.
3. The cammittee is in favar af a pasitive appraach ta this prablem as set farth in Resalutian #7.
4. The cammittee is appased ta a negative appraach ta this prablem as set farth in Resalutian #4.

8

AMA MEMBERSHIP OPINION POLLS

From the Bergen County Medical Society

(Reference Committee "H")

Whereas, concerning many matters of social and economic importance, the delegates to the AMA are not, and, under present conditions, cannot be cognizant of the wishes of many of the doctors representing the several (academic, industrial and practice) disciplines in their communities, and

Amended ta read: "Whereas, cancerning many matters af sacial and ecanamic impartance, the delegates ta the AMA may not be cagnizant af the wishes af many af the dactars representing the several (academic, industrial, and practice) disciplines in their cammunities; and"

Whereas, in certain instances, the votes of certain delegates as individuals and as blocs have been against the expressed wishes of their constituents, and

Whereas, in times past, the American Medical Association has accepted and rejected matters of great importance (viz. the Bricker Amendment, Social Security for doctors and the like) without consulting the membership at large, and

Amended ta read: "Whereas, in times past, the American Medical Assaciatian has accepted and rejected matters af great impartance withaut cansulting the membership at large; and"

Whereas, because certain activities of this sort have been the cause of resentment on the part of a number of our members, many have relinquished their membership; therefore be it

Amended ta read: "Whereas, because certain activities af this sart have been the cause af dissatisfaction on the part af a number af aur members, many have relinquished their membership; therefore be it"

RESOLVED, that, henceforth, in matters of great or even moderate importance, that require no immediate decision, the membership be polled* to obtain an expression of opinion, the question to be phrased fairly by an impartial group for this purpose, and our delegates and Trustees be admonished to be guided by the result of such inquiry; and be it further

The wards "be admanished" were deleted.

RESOLVED, that our delegates to the AMA present this resolution to the House of Delegates at the Annual Meeting, June 21-25, 1964, in San Francisco, California.

*A ballot to be part of the American Medical Association "News" would be a suitable and rapid procedure.

Adapted as amended (page 336)

9

TRAINING FAMILY DOCTORS IN NEW JERSEY MEDICAL SCHOOLS

From Nicholas E. Marchione, M.D.,
Delegate from Cumberland County

(Reference Committee "D")

Whereas, a new State Medical School in New Jersey is being planned at Rutgers University, a development of paramount importance to our people, who have experienced a shortage of family doctors in many communities, and

Whereas, the people are entitled to expect that their public funds used in this school will produce more family practitioners, and

Whereas, in another State, passing of pending legislation would insure that a public medical school must train family doctors for its own expanding population; therefore be it

RESOLVED, that the school should be dedicated to produce more family practitioners to meet the growing health needs of the people of this State; and be it further

Amended to read: "RESOLVED, that the school should be encouraged to produce more family practitioners to meet the growing health needs of the people of this State; and be it further"

RESOLVED, that a copy of the Resolution be sent to the Governor as well as to the members of the New Jersey Senate and the Assembly.

Adopted as amended (page 328)

10

LEGISLATION TO MAKE MEDICAL STUDIES CONFIDENTIAL

From the Middlesex County Medical Society

(Reference Committee "E")

Whereas, the Middlesex County Medical Society of the State of New Jersey has been advised that there has been or is about to be introduced in the legislature of the State of New Jersey, a proposed bill, which if passed, will provide that medical studies conducted by the New Jersey Department of Public Health, New Jersey State Medical Society, allied medical societies and in-hospital staff committees of accredited hospitals, will be of confidential character and shall be used only for medical research and that said information, records, reports, statements, notes, memorandums and all other data shall not be admissable as evidence in any action of any kind, in any Court or before any tribunal, board, agency or person, and

Whereas, the Middlesex County Medical Society strongly urges the passage of such bill into law and does so because it is of the opinion that it will advance the science of medicine, treatment of patients and freedom of medical study for the public generally; now therefore be it

RESOLVED, that, the Middlesex County Medical Society of New Jersey does hereby recommend and urge the passage of said Bill as aforesaid and that a copy of this resolution be sent to the New Jersey State Medical Society and the New Jersey State Hospital Association.

Approved (page 331) and referred to the Council on Legislation for its support.

11

AMENDMENT OF THE MEDICAL PRACTICE ACT TO PROTECT MEDICAL TECHNICIANS

From the Essex County Medical Society

(Reference Committee "E")

Whereas, a legal opinion has been rendered by the Attorney General that the use of an orthoptic technician is illegal in the State of New Jersey even under the direction of an ophthalmologist, and

Whereas, at the present time the prohibitory provisions of the Medical Practice Act apply to all ancillary personnel except those specifically excluded under section K of 45:9-21, namely—"A chiropodist, professional nurse, registered physical therapist, masseur, while operating in each particular case under the specific direction of a regularly licensed physician or surgeon" . . .; and

Whereas, orthoptic technicians are trained by ophthalmologists and are certified by the American Association of Orthoptic Technicians which is an arm of the American Academy of Ophthalmology and Otorhinolaryngology, and are therefore under direct medical supervision; and

Whereas, the current interpretation of the Medical Practice Act in these restrictions regarding medical technicians undermines approved good medical practice by excluding trained medical personnel; and

Whereas, this affects Ophthalmologists, Pathologists, Internists, Roentgenologists, and all aspects of medical practice; now therefore be it

RESOLVED, that The Medical Society of New Jersey move swiftly toward the introduction and passage of legislation pertaining to these prohibitory provisions of the Medical Practice Act and include medical technicians (which term includes orthoptic technicians); and be it further

RESOLVED, that such enactment would insure the continuance of ancillary services presently threatened, the withdrawal of which would result in greatly impaired service to the public of New Jersey.

Not adopted (page 331), since such legislation is already under consideration, as mentioned in the report of the Council on Legislation (page 279).

12

DISPOSING OF DRUG SAMPLES

From Edwin H. Albano, M.D., Delegate from Essex County

(Reference Committee "A")

Whereas, certain lay people have recently visited physicians' offices to purchase unwanted drug samples to be again repackaged and resold to the public; and

Whereas, these samples provided by pharmaceutical houses, free of charge to physicians, are intended to be used without expense to physicians or patients; and

Whereas, the entrusting of them to the custody of any person other than a physician would expose the ultimate user to the dangers of employing pharmaceuticals that are out of date and therefore scientifically undependable; and

Whereas, the members of the Judicial Council of The Medical Society of New Jersey on December 4, 1960, unanimously recorded themselves as of the opinion that "The selling of these samples by physicians to any person or agency is both unethical and unprofessional;" therefore be it

RESOLVED, that all members of The Medical Society of New Jersey be urged to dispose of all unwanted samples in a safe manner so that these drugs cannot endanger the public; and be it further

RESOLVED, that all members be reminded that the sale or the improper disposition of these samples to any unauthorized person or persons is not compatible with the Principles of Medical Ethics and the standards of professional conduct.

Amended to read: "RESOLVED, that all members be reminded that the sale or the improper disposition of these samples is not compatible with the Principles of Medical Ethics and the standards of professional conduct."

Approved as amended (page 325), with the recommendation that members exercise care in disposing of all materials and equipment, such as disposable syringes, that might be injurious or dangerous in improper hands.

13

ENDORSEMENT OF JEMPAC

From the Monmouth and Ocean County Medical Societies

(Reference Committee "E")

Whereas, The Medical Society of New Jersey has recorded its approval of the aims and objectives of the New Jersey Medical Political Action Committee (JEMPAC) at its 1963 Annual Meeting, and

Whereas, endorsement of **the aims and efforts of** JEMPAC is a most effective means of promoting the interests of patients and physicians of New Jersey in the field of politics; therefore be it

Amended to include the words "the aims and efforts of," as indicated.

RESOLVED, that The Medical Society of New Jersey encourages and endorses the aims and efforts of JEMPAC and urges its members to join and contribute to it.

Approved as amended by the House (page 331).

MEMORIAL RESOLUTION

As the first item of business, the 1964 House unanimously adopted—without referral—the following resolution in memory of

ROYAL ALBERT SCHAAF, M.D.

WHEREAS, Almighty God has seen fit to summon from our midst His good servant and our beloved colleague, Royal Albert Schaaf, M.D.; and

WHEREAS, in his long career as a surgeon of high competence, Doctor Schaaf distinguished himself as one who loved and served mankind; and

WHEREAS, by the generous gift of his time and talents, he worked assiduously and effectively for the economic and social welfare of all his fellowmen; and

WHEREAS, with singular and unselfish devotion through his entire career, he served well The Medical Society of New Jersey and reflected honor upon it by his achievements as President and member of the Board of Trustees; now therefore be it

RESOLVED, that this House of Delegates, in convention assembled, recognizing Royal Albert Schaaf, M.D. as a man of great personal worth and professional eminence, record its profound grief at his passing; and be it further

RESOLVED, that a copy of this resolution be spread upon the minutes of this meeting, and that another copy, suitably prepared, be presented to his bereaved family.

REFERENCE COMMITTEES

REFERENCE COMMITTEE ON CONSTITUTION AND BYLAWS

Frederick W. Durham, M.D., Chairman

The Reference Committee on Constitution and Bylaws met on Sunday, May 17, 1964, with all members present: Doctors Marshall F. Driggs, Rudolph G. Matflerd, Edward G. Gullord, Clement M. Jones, and the chairman.

1. Committee on Revision of Constitution and Bylaws (page 278)

The report of the Committee on Revision of Constitution and Bylaws was gratifyingly brief and unequivocally accepted. The reference committee *recommends* its adoption.

Adopted

2. Proposed Amendment to Bylaws, Resolution #5 (page 318)

Burlington County's resolution, to effect an amendment of the Bylaws, was deliberated. The resolution proposes an increase of dues for Associate Members from the present 1/3 of the current per capita assessment for Regular Members to 2/3 of that assessment.

The reference committee *recommends* approval of this resolution.

Adopted

Report adopted as a whole

REFERENCE COMMITTEE "A"

William J. D'Elia, M.D., Chairman

Reference Committee "A" met on Sunday, May 17, 1964, with the following members present: Doctors Raphael E. Remondelli, John P. Coughlin, Ralph E. Siegel, and the chairman. Approximately 10 delegates and members were present to discuss the various items under consideration.

1. President (page 249)

The report was carefully reviewed. The committee took special note of the amount of work, time, and sacrifice involved in the presidency and wishes to express gratitude to the president for all that he has done in the course of his crowded year.

The committee *recommends* approval of the president's report.

Adopted

2. Board of Trustees (page 255)

The committee wishes to inform the members that copies of the official minutes of The Medical Society of New Jersey Board of Trustees are regularly available for their reference in the offices of component medical societies.

The introductory section of this report, covering the general activities of the Board, was reviewed and approved.

The committee *recommends* approval of this portion of the report.

Adopted

A. Bicentennial History (page 255)

Your committee noted with approval that the Board of Trustees has engaged the services of Mrs. Arlene R. Sayer of Trenton to prepare the official history of The Medical Society of New Jersey.

The committee *recommends* approval of this portion of the report.

Adopted

B. Inter-Relations with the Judiciary and Bar (page 255)

The committee *recommends* approval of this portion of the report.

Adopted

C. Reports of AMA Delegates (page 256)

Following each AMA meeting, the chairman of the delegation has submitted a detailed report to the Board of Trustees, which has been appended to the official minutes of the Board and thus distributed to component societies.

The committee *recommends* approval of this portion of the report.

Adopted

D. D.O. to M.D. Conversion in California (page 256)

As suggested by the reference committee and approved by the 1963 House, the Board referred this action of the House to Legal Counsel with the request that he consult with the Deputy Attorney General for the State Board of Medical Examiners.

The committee *recommends* approval of this portion of the report.

Adopted

3. Secretary (page 250)

This report was thoroughly reviewed and its many aspects discussed. During the discussion it was noted that of a total of 6500 physicians, 5849 members of The Medical Society of New Jersey maintain active membership in the AMA. The Society's representation in the AMA House of Delegates is computed on the basis of one delegate for each thousand members, or fraction thereof. With the addition of 151 new active members in the AMA, The Medical Society of New Jersey would gain an additional delegate. Your committee urges that a strong effort be made to obtain this desirable increase in AMA members from New Jersey.

The committee *recommends* approval of the Secretary's report.

Adopted

4. Judicial Council (page 264)

The committee reviewed and discussed thoroughly the report of the Judicial Council, including the account of the highly informative Judicial Conference Meeting of November 1963.

The committee *recommends* approval of the report.

Adopted

5. Executive Director (page 262)

The report of the Executive Director was reviewed with great interest. The committee wishes to express thanks to Mr. Nevin for his help and guidance.

The committee *recommends* approval of this report.

Adopted

6. Committee on Credentials (page 267)

The report was reviewed. We *recommend* its approval.

Adopted

7. Disposing of Drug Samples, Resolution #12 (page 322) from Edwin H. Albano, delegate from Essex County

A discussion developed among the members present regarding the disposition of these samples. The committee *recommends* that the last paragraph be amended to read:

RESOLVED, that all members be reminded that the sale or the *improper* disposition of these samples is not compatible with the Principles of Medical Ethics and the standards of professional conduct.

In the spirit of the resolution, the committee *recommends* that our members exercise care in disposing of all materials and equipment, such as disposable syringes, that might be injurious or dangerous in improper hands.

The committee *recommends* approval of the resolution as amended.

Adopted

Report adopted as a whole

REFERENCE COMMITTEE "B"

David Eckstein, M.D., Chairman

Reference Committee "B" met on Sunday, May 17, 1964, with all members present: Doctors Nicholas E. Marchione, Earl L. Warren, Ernest C. Hillman, Jr., Eugene J. Tyrrell, and the chairman. Approximately 15 delegates and members were present to discuss the various items under consideration.

1. Board of Trustees
   Academy of Medicine of New Jersey
   (page 256)

The committee heard interesting and convincing arguments in favor of a donation for the year 1964-65. It was impressed with the record of service of the Academy of Medicine, and *recommends* to the House of Delegates that it approve a contribution to this worthwhile agency. The suggested amount is spelled out in another report (Finance and Budget — page 268), and we *recommend* that the House of Delegates vote upon the merits of the request.

Adopted

2. Treasurer (page 251)

The committee read with interest and awe the report of the Treasurer, and commended him and his staff for work and valor beyond the call of duty.

We *recommend* that the report of the Treasurer be accepted as presented.

Adopted

3. Committee on Finance and Budget (page 268)

The Committee on Finance and Budget, under the chairmanship of Dr. Carl N. Ware, had to meet several serious problems, and we feel that its budgetary solutions are rational and reasonable. To facilitate action by the House, we present the report in parts:

A. We *recommend* that the report on THE JOURNAL be approved as printed.

Adopted

B. We *recommend* that the 1965 assessment be adopted at $40 per capita, with no provision for contribution to AMA-ERF; and we further *recommend* that each man contribute to AMA-ERF according to the designations of his conscience to the school of his choice.

Adopted

C. Your committee *recommends* that the House approve a special per capita assessment of $5 per man for the year 1965; and that, if the House of Delegates votes this special per capita assessment, it serve as a contribution to the Medical Student Loan Fund (50% of total); to the Bi-Centennial Fund (25% of total); and to the Library of the Academy of Medicine of New Jersey (25% of total); and that this assessment not be a part of the budgetary assessment, but that it be billed at the same time.

Adopted

D. The budget was dealt with in such detail as to uncover and correct a minor arithmetical error in the work sheets covering estimated deficits and balances for 1963-64. The committee found the budget as presented sound and accurate, and *recommends* that it be approved.

Adopted

4. Medical Student Loan Fund (page 275)

The committee *recommends* the acceptance of the report on the Medical Student Loan Fund as printed, and commends Dr. Mulligan and his committee for their splendid record.

Adopted

5. Publication (page 277)

The committee recognizes the tremendous strides by the committee in producing a better and more informative JOURNAL. We commend Dr. Sharbaugh, Dr. Davidson, Miss Gocke, and the committee for presenting an educational and readable JOURNAL.

We *recommend* approval of the report of the Publication Committee.

Adopted
Report adopted as a whole

REFERENCE COMMITTEE "C"

Theodore K. Graham, M.D., Chairman

Reference Committee "C" met on Sunday, May 17, 1964, with the following members present: Doctors John S. Madara, Edwin H. Albano, George E. Barbour, and the chairman. Approximately 30 delegates and members were present to discuss the various items under consideration.

1. Board of Trustees

A. Group Health Insurance (page 257)

The committee *recommends* approval of this report.

Adopted

B. Medical-Hospital Liaison Committee (page 257)

The committee *recommends* approval of this report.

Adopted

C. MSP Board of Trustees' Nominations (page 258)

The committee approves the nominations contained on page 9 of the printed report and those mimeographed, and *recommends* their approval by the House.

Adopted

D. MSA Board of Governors' Nominations (page 259)

The committee approves the nominations contained on page 11 of the printed report and those mimeographed, and *recommends* their approval by the House.

Adopted

There was some discussion concerning the fact that there are no nominations for either MSP or MSA from the southern counties. The committee wishes to bring to the attention of the component societies the fact that they are privileged to make recommendations to the nominating committee of Medical-Surgical Plan and Medical Service Administration.

Adopted

2. Medical-Surgical Plan of New Jersey (page 309)

After considerable discussion, it was *recommended* that each component society reactivate or establish the advisory committee to the Medical-Surgical Plan for development of better physician-Plan understanding and to encourage increased physician participation in the Plan.

Adopted

The committee *recommends* approval of the report of Medical-Surgical Plan and asks the members of the House of Delegates to call the attention of the members of their component societies to the importance of their giving full cooperation in filling out questionnaires for the Test Performance Survey presently being conducted by Medical-Surgical Plan of New Jersey as part of a national survey.

Adopted

3. Medical Service Administration of New Jersey (page 306)

The committee *recommends* approval of this report.

Adopted

Report adopted as a whole

REFERENCE COMMITTEE "D"

Edward A. Schauer, M.D., Chairman

Reference Committee "D" met on Sunday, May 17, 1964, with all members present: Doctors G. Ruffin Stamps, John F. Johnson, Robert F. Zimmerman, Dorsett L. Spurgeon, and the chairman. Approximately 20 delegates and members were present to discuss the various items under consideration.

1. Family Doctors in New Jersey Medical Schools, Resolution #9 (page 321)

This resolution was presented by Nicholas E. Marchione, M.D., delegate from Cumberland County. After much discussion, the committee *recommends* that the first "resolved" be amended to read: "RESOLVED, that the school should be *encouraged* to produce more family practitioners to meet the growing health needs of the people of this State," and that the resolution be adopted as amended.

Adopted

2. Implementation of AMA Resolution #68, Resolution #6 (page 319)

Resolution #6 was presented by the Essex County Medical Society. The committee agrees with the intent of this resolution, and *recommends* that it be adopted.

Adopted

3. Board of Trustees

AMA Intern Approval Program (page 259)

The committee next considered that portion of the Board of Trustees' Report concerned with the AMA Intern Approval Program. This portion of the report of the Board was approved by the committee.

The committee *recommends* approval of this portion of the report.

Adopted

4. Committee on Medical Education (page 273)

The reference committee agreed with the first two sections of this report, including six suggestions to increase interns and residents in New Jersey and three suggestions to attract more residents to individual hospitals.

The committee *recommends* approval of these portions of the report.

Adopted

The committee then discussed the third heading of the report, namely, "The Medical Society of New Jersey may be of aid by."

The committee *recommends* approval of this portion of the report with one exception. The committee takes exception to the last three words of the second suggestion in this portion of the report—the words "diminished language requirements."

Adopted

The committee *recommends* that this section (#2) be amended to read as follows: "Negotiating with the ECFMG to provide more realistic tests and to afford foreign interns the opportunity to take Board examinations in their native tongue if desired."

Rejected (motion to approve lost)

Your committee *recommends* the addition of the following added "suggestion" to this section of the report: "6. That each intern, resident, and house officer have a councilor from the medical staff of his hospital."

Adopted

The committee then considered the specific recommendations to the Board of Trustees of the Committee on Medical Education. The committee agrees with the first two recommendations of the Committee on Medical Education, and *recommends* their approval.

Adopted

With reference to the third recommendation of the committee (page 274), it was felt that a slight amendment was indicated. The committee therefore *recommends* that this section

be amended to read: "The Board of Trustees is requested to designate a representative to discuss the possibility of further dissemination of information on available opportunities in New Jersey to foreign medical schools and the possibility of setting up a central bureau for recruiting Interns, Residents, and House Officers in New Jersey, with *the consultative assistance of* Dr. Hilton Read and the Ventnor Foundation."

Adopted

The committee *recommends* approval of recommendation #4 (page 274), but seriously questions its practicality.

Adopted

The committee *recommends* approval of recommendation #5 (page 274) and of the remainder of the report.

Adopted

5. Committee on Medical Defense and Insurance (page 270)

This report includes major medical expense insurance, accident and health insurance, high limit accident policy, life insurance, and professional liability insurance. At the reference committee meeting, Dr. Featherston pointed out several errors in the report. These should be corrected for the record. These errors include (1) under life insurance, page 34, the third line of the first paragraph, the figure should be $23,690,000; (2) in the second line of the second paragraph under life insurance on page 34, the word *not* should replace the word *set*; (3) in the sixth paragraph under professional liability on page 36, second line, the figures should be $100,000 per claim and $300,000 aggregate.

The committee *recommends* the approval of this report as corrected, including the two formal recommendations:

(1) That the E. & W. Blanksteen Agency be continued as the official brokers for our Major Medical Expense Insurance, Accident and Health, Life Insurance, and High Limit Accident Insurance Programs.

(2) That the American Mutual Liability Insurance Company be continued as the officially designated carrier for our professional liability insurance program.

Adopted

The reference committee wishes to commend the Committee on Medical Defense and Insurance for making available such a wide choice of insurance to the members of The Medical Society of New Jersey.

6. Committee on Retirement Plan for Physicians (page 301)

The committee next considered the Retirement Plan for Physicians as presented by Nicholas E. Marchione, M.D., Vineland.

The committee considered the first six paragraphs of the report, and *recommends* approval of them.

Adopted

The committee then considered the recommendation of the Committee on Retirement Plan for Physicians, and was in agreement that the committee should be continued.

Your committee *recommends* approval of the recommendation.

Adopted

The committee then considered the specific items under the statement issued by the Board of Trustees, December 17, 1963, and felt that three points should now be stressed.

Under reason #1 of this report, "the Mercer County plan has not as yet been approved by the Internal Revenue Service," the committee noted that this plan has now been approved.

The committee felt that reason #5 should be called to the attention of the House of Delegates in that there are benefits to be derived from any available plan if a physician employs no more than one person. If the physician employs more than one person, the benefits begin to decrease. In view of this, your reference committee *recommends* that a survey of our members be made to determine the number of physicians who have no employees or employ no more than one person. Your committee feels that this should help the Com-

mittee on Retirement Plan for Physicians in its decision as to whether a plan of this nature should be instituted in New Jersey.

Adopted

Having made these comments with reference to the statement issued by the Board of Trustees, the committee felt that this portion of the report should be approved as presented, and we therefore *recommend* approval.

Adopted

The committee *recommends* that the report of the Committee on Retirement Plan for Physicians be approved.

Adopted

Your chairman wishes to thank the members of Reference Committee "D" for their time and effort in presenting this report to the House of Delegates.

Report adopted as a whole, as amended

REFERENCE COMMITTEE "E"

Elmer L. Grimes, M.D., Chairman

Reference Committee "E" met in the Rowsley Room on Sunday, May 17, 1964, with all members present: Doctors Robert E. Verdon, Millard Cryder, William R. Jacobs, Donald T. Akey, and the chairman. Approximately 17 delegates and members were present to discuss the various items under consideration.

1. Board of Trustees

   Professional Service Corporation Act (page 259)

The committee read with interest the comments of the Board of Trustees relative to the Professional Service Corporation Act and commends the Society for taking this action.

The committee *recommends* approval of this portion of the report.

Adopted

2. Council on Legislation (page 279)

The committee reviewed the approved and disapproved material presented by the Council on Legislation, under the chairmanship of Dr. Jesse McCall. Doctor McCall pointed out that, despite all the Society's efforts, the 1963 Legislature did not enact the amendment to the Medical Practice Act that would extend legal protection to medical and x-ray technicians acting at the specific direction of a licensed physician (S-138 of 1963). The Governor and the Legislature have balked at the general term of "medical technician" thus far. The council, after deriving a satisfactory definition for medical technician, will re-double its efforts to enact an effective amendment.

The committee *recommends* approval of this report.

Adopted

3. Council on Public Relations (page 292)

The committee reviewed the report of the Council on Public Relations, under the chairmanship of Dr. John F. Kustrup. It noted the continued and dynamic progress of this council, and commends the council for its effectiveness.

The committee *recommends* approval of this report.

Adopted

4. Pre-Employment Physical Examinations, Resolution #2, (page 316)

The committee, with the approval of Dr. Weinstein as representing the Sussex County Med-

ical Society, offers the following amended version of the resolution:

Whereas, there is *at present* a lack of consistency in the methods of *choice of* physicians *to* examine minors under 18 for working papers; and

Whereas, the principles of free choice of physician and of fee for service are the accepted, customary methods of medical practice; and

Whereas, the school system must always have the ultimate control and responsibility in supervising scholastic performance; now therefore be it

RESOLVED, (1) that pre-employment physical examinations should be performed by freely chosen physicians or designated physicians; and

Amended to read: "RESOLVED, (1) that pre-employment physical examinations should be performed by either freely chosen or designated physicians; and"

(2) that the Medical Society of New Jersey develop and actively support the passage of amendments to existing legislation necessary for accomplishment of the above ends.

The committee *recommends* approval of this resolution as amended.

Adopted as amended

5. Legislation to Make Medical Studies Confidential, Resolution #10 (page 321)

The committee *recommends* approval of this resolution and its referral to the Council on Legislation for its support.

Adopted

6. Amendment to the Medical Practice Act to Protect Medical Technicians, Resolution #11 (page 322)

The committee pointed out that such legislation is already under consideration (S-138 of 1963), as mentioned under our discussion of the Council on Legislation's report and notation that the council will re-double its efforts to bring about such an amendment.

It therefore *recommends* that the resolution be not adopted.

Adopted

7. Endorsement of JEMPAC, Resolution #13 (page 323)

Following a lively discussion, it appeared to the committee that the bulk of the group of visiting delegates favored the active support of JEMPAC and would encourage the Society's support.

The committee *recommends* approval of this resolution.

Second paragraph of the resolution amended to read: "Whereas, endorsement of the aims and efforts of JEMPAC is a most effective means of promoting the interests of patients and physicians of New Jersey in the field of politics; therefore be it"

Adopted as amended

The committee chairman thanks the members of the committee and the visiting delegates and members for their support in actively discussing the above items under consideration.

Report adopted as a whole, as amended.

REFERENCE COMMITTEE "F"

John B. Fuhrmann, M.D., Chairman

Reference Committee "F" met on Sunday, May 17, 1964, with all members present: Doctors A. Guy Campo, Edward M. Coe, Charles L. Cunniff, Raymond A. Taylor, and the chairman. Approximately 50 delegates and members were present during the meeting, and at least 25 took part in the discussion of the various items under consideration.

1. Health Facilities Planning Council (page 260)—referred from the Board of Trustees—plus Resolution #4 (page 317) and Resolution #7 (page 319) both entitled "Area-Wide Planning for Hospitals"

These topics are considered together, as they pertain to the same matter. The committee

concurs in the opinion of the Board of Trustees as expressed on page 260. Your committee *recommends disapproval* of Resolution #4 and *approval* of Resolution #7 for the following reasons:

A. The committee is in favor of VOLUNTARY area planning without governmental interference.

B. The committee is in favor of VOLUNTARY area planning on a local level.

C. The committee is in favor of a positive approach to this problem as set forth in Resolution #7.

D. The committee is opposed to a negative approach to this problem as set forth in Resolution #4.

Resolution #7 was amended by the House: an introductary paragraph was inserted and two clasing paragraphs inserted.

Adapted as amended

* 2. Hospital Bylaws (page 260) — referred from the Board of Trustees

The committee heard extended discussion of this statement of the Board of Trustees and *recommends* that the House record its approval of the statement as issued, namely: "An applicant for a staff position must be a member of that professional society or association in which his doctoral degree entitles him to hold membership." There were some proposed additions presented to the reference committee for inclusion in this statement. The committee decided, with Legal Counsel's approval, that they were superfluous.

Adopted

3. Impartial Medical Experts (page 260)—referred from the Board of Trustees

The committee *recommends* that this item be received as informative only.

Adopted

4. Welfare Prescriptions and Vendor Voucher Forms (page 261)—referred from the Board of Trustees

The committee agrees with the opinion of the Board in these matters and *recommends* approval.

Adapted

5. Council on Medical Services (page 286)

A. The committee *recommends* that the sections on (1) accreditation of nursing homes, (2) utilization of hospital beds, and (3) anesthesiologist participation in MSP be received as progress reports and for information only.

Adapted

* B. The committee *recommends* that the section on Physician-Hospital Relationships and the supplemental report containing the final revised version of the "Proposed Guides for Physician-Hospital Relationships in New Jersey" be approved. In connection with the "Proposed Guides," it is noted that the terms (1) "active medical staff" and (2) "other broadly-based segment of the medical staff" are not herein defined; their definition should be left to the medical staff of the respective hospitals.

Adapted

* 6. Rights of Physicians in Hospitals, Resolution #3 (page 317)

This resolution is accepted and *approved* with the same notation as to the terms (1) "active medical staff" and (2) "other broadly-based segment of the medical staff" as in the previous section of the report.

Adopted

7. Special Committee on Occupational Health (page 294)

This is *received* as a progress report.

Adapted

8. Special Committee on Workmen's Compensation (page 294)

This report is received and *approved,* and the recommendations accepted.

Adapted

Report adopted as a whole, as amended. The House directed that certain recommendations (*) be sent to the president and secretary of all medical staffs, to hospital administrators, and haspital lay boards in New Jersey.

REFERENCE COMMITTEE "G"

Winton H. Johnson, M.D., Chairman

Reference Committee "G" met on Sunday, May 17, 1964, with all members present: Doctors Norman K. Boudwin, John J. Torppey, Joshua N. Zimskind, C. Spencer Davison, and the chairman. Approximately 15 delegates and members were present to discuss the various items under consideration.

1. Board of Trustees
   Polio Immunization (page 261)

The committee was happy to see the good cooperation of the county societies in the anti-polio programs.

The committee *recommends* approval of this item.

Adopted

2. Council on Public Health (page 290)

The Council on Public Health had a rather lengthy report and the various items contained in the printed report were considered, as follows:

A. Tuberculosis Control (page 290)

The committee *recommends* that the last "Resolved"—as approved by the Board of Trustees—be amended (italicized) as follows:

> "Resolved, that The Medical Society of New Jersey emphasize and endorse the principle of state payment of full cost in city as well as county hospitals for *medically indigent* tuberculous patients." . . . and that this section of the report be approved as amended.

Adopted

B. Reporting of Communicable Diseases (page 290)

The committee *recommends* approval of this item.

Adopted

C. Cigarette Smoking and Lung Cancer (page 291)

There was a lively discussion among those present. The committee suggests that the AMA be more positive in its approach to the cancer problem and smoking, and through state and local societies and individual physicians carry its message to the public. Also, the harmful effects of smoking in conditions other than cancer should be emphasized; for example, in heart disease.

The committee *recommends* approval of this item.

Adopted

D. Sewage Disposal Pollution (page 291)

The committee *recommends* approval of this item.

Adopted

E. Recommendation (page 291)

The committee *recommends* approval of this recommendation to authorize the Board of Trustees to appoint a committee to re-evaluate the special committee structure of the Society.

Adopted

The committee *recommends* approval of this report.

Adopted

3. Special Committee on Cancer Control (page 295)

The committee *recommends* approval of this report.

Adopted

4. Special Committee on Child Health (page 295)

The committee commends the special committee for its excellent work during the past year.

The committee *recommends* approval of this report.

Adopted

5. Special Committee on the Chronically Ill and the Aging (page 296)

The committee recommends that the last paragraph of this report be amended as follows:

"That The Medical Society of New Jersey urge its members in their general physical examination of elderly individuals to do routine *chest* x-rays (tests) to rule out tuberculosis."

The bracketed word is to be deleted; the *italicized* word is to be added.

The discussion of this problem brought out the fact that many mobile units are being disbanded throughout the State. The chest x-rays of medically indigent people may be obtained through clinics or regional county hospitals.

The committee *recommends* approval of this report as amended.

Adopted

6. Special Committee on the Conservation of Hearing and Speech (page 297)

The committee *recommends* approval of this report.

Adopted

7. Special Committee on the Conservation of Vision (page 297)

The School Eye Symposium given under the joint sponsorship of Hudson, Essex, and Union Counties met with excellent success. The reference committee adds the suggestion that The Medical Society of New Jersey encourage the other counties to support similar symposia in their areas.

The committee *recommends* approval of this report.

Adopted

8. Special Committee on Maternal and Infant Welfare (page 298)

The committee *recommends* approval of this report.

Adopted

9. Special Committee on Mental Health (page 298)

The committee *recommends* approval of this report.

Adopted

10. Special Committee on Rehabilitation (page 299)

The committee *recommends* approval of this report.

Adopted

11. Committee on Traffic Safety (page 303)

There was considerable discussion, and many good thoughts on this problem were elicited. Dr. Sprout, chairman of the committee, helped in answering many of these questions. The reference committee realizes that there are many areas for discussion but that as a starting point this report is worthy of our approval.

The committee *recommends* that the last paragraph of this report be amended to the extent that copies of this report, if approved by the House of Delegates, will be sent to the respective departments with copies to the individuals named in the recommendation.

Adopted

The committee *recommends* approval of this report as amended.

Adopted

12. Drug Addiction Problems, Resolution #1 (page 316)

The committee *recommends* approval of this resolution.

Adopted

The chairman thanks all members present, particularly those who took part in discussions.

The members of the committee and the work done by all the committees whose reports were dealt with by the reference committee reflected a tremendous amount of work on the part of the committee members.

Report adopted as a whole

REFERENCE COMMITTEE "H"

Elbert H. Pogue, M.D., Chairman

Reference Committee "H" met on Sunday, May 17, 1964, with all members present: Doctors Donald W. Bowne, William L. Palazzo, Irving Chrisman, Joseph R. Burns, and the chairman. Approximately 12 delegates and members were present to discuss the various items under consideration.

1. Board of Trustees

A. Committee on Medicine and Religion (page 261)

There was no discussion on this matter. The committee *recommends* approval of the item as it appears in the printed annual reports.

Adopted

B. Nursing Education and Recruitment (page 262)

This item was received by the committee as informative in connection with the handbook report of the Committee on Nursing Education and Recruitment.

Adopted

2. Committee on Annual Meeting (page 265)

The report of this committee was read. After this, a spirited discussion followed in which it was suggested that the Committee on Annual Meeting be advised that some delegates to the convention of The Medical Society of New Jersey have complained that, despite reservations confirmed by mail, they have been unable to secure rooms until late evening hours. This has happened repeatedly. Several other complaints were brought out, including the amount of noise made by young female revelers.

"made by young female revelers" was deleted by the House.

In view of the long association of The Medical Society of New Jersey with this hotel and the desirability of continuing to meet here, the reference committee *recommends* that these matters be taken up with the proper authorities for their attention.

The reference committee *recommends* approval of this report.

Adopted as amended

A. Subcommittee on Scientific Exhibits (page 266)

The committee *recommends* approval of this report as printed.

Adopted

B. Subcommittee on Scientific Program (page 266)

The Committee *recommends* approval of this report as printed.

Adopted

3. Committee on Honorary Membership (page 267)

The *recommendation* of the Committee on Honorary Membership was approved by the reference committee as printed. The House of Delegates elected Dr. Sabin to Honorary Membership at its first session on Saturday, May 16, 1964.

Adopted

4. Committee on Nursing Education and Recruitment (page 300)

There was considerable discussion of this report. The reference committee *recommends* that several ideas be considered by the Committee on Nursing Education and Recruitment:

1. That wherever possible more students of nursing be accommodated by allowing first year students to live outside of dormitories.

2. That further acceptance of male nurses be encouraged.

3. That state scholarships for student nurses be sought, similar to scholarships granted for college students.

4. That hospitals operating nursing schools be encouraged to preserve them.

5. That more realistic salaries for nurses be adopted to encourage students to enter and to stay in nursing.

The reference committee commends the Committee on Nursing Education and Recruitment for its continued efforts, and *recommends* approval of this report.

Adopted

5. Committee on Disaster Medical Care (page 300)

The committee *recommends* that this report be approved as published in the printed record.

Adopted

6. Advisory Committee to the Woman's Auxiliary (page 278)

The committee *recommends* that this report be approved as presented.

Adopted

7. Nominations for Emeritus Membership (page 305)

The committee *recommends* that this report be approved as presented.

Adopted

8. AMA Membership Opinion Polls, Resolution #8 (page 320)

There was considerable discussion of this resolution from the Bergen County Medical Society. It was decided that, with certain changes, the resolution should be *recommended* by the reference committee for approval, as follows:

Whereas, concerning many matters of social and economic importance, the delegates to the AMA *may not* be cognizant of the wishes of many of the doctors representing the several (academic, industrial, and practice) disciplines in their communities; and

Whereas, in certain instances, the votes of certain delegates as individuals and as blocs have been against the expressed wishes of their constituents; and

Whereas, in times past, the American Medical Association has accepted and rejected matters of great importance without consulting the membership at large; and

Whereas, because certain activities of this sort have been the cause of *dissatisfaction* on the part of a number of our members, many have relinquished their membership; therefore be it

RESOLVED, that, henceforth, in matters of great or even moderate importance that require no immediate decision, the membership be polled* to obtain an expression of opinion, the question to be phrased fairly by an impartial group for this purpose, and our delegates and Trustees to be guided by the result of such inquiry; and be it further

RESOLVED, that our delegates to the AMA present this resolution to the House of Delegates at the Annual Meeting, June 21-25, 1964, in San Francisco, California.

*A ballot to be part of the American Medical Association "News" would be a suitable and rapid procedure.

Adopted

Your chairman is grateful to the members of Reference Committee "H" for the time and effort given to deliberation, and also to the delegates who participated in the discussions. He also wishes to thank Dr. Lloyd A. Hamilton, Dr. Joseph R. Jehl, and Dr. Samuel J. Lloyd for their advice and guidance.

Report adopted as a whole, as amended

REPORT OF THE NOMINATING COMMITTEE

May 16, 1964

OFFICE	TERM	FROM	TO	NOMINEE and COUNTY
President-Elect	1 year	May 1964	May 1965	John J. Bedrick, Hudson
1st Vice-President	1 year	May 1964	May 1965	Joseph R. Jehl, Passaic
2nd Vice-President	1 year	May 1964	May 1965	Louis K. Collins, Gloucester
Secretary	1 year	May 1964	May 1965	Marcus H. Greifinger, Essex
Treasurer	1 year	May 1964	May 1965	Daniel F. Featherston, Monmouth
Trustees:				
1st District	3 years	May 1964	May 1967	Emanuel M. Satulsky, Union
4th District	3 years	May 1964	May 1967	Louis F. Albright, Monmouth
5th District	3 years	May 1964	May 1967	A. Guy Campo, Gloucester
Judicial Councilors:				
3rd District	3 years	May 1964	May 1967	Albert F. Moriconi, Mercer
5th District	1 year	May 1964	May 1965	John S. Madara, Salem
	(unexpired term of Isaac N. Patterson, resigned)			
AMA Delegates:	2 years	Jan. 1965	Dec. 1966	C. Byron Blaisdell, Monmouth
	2 years	Jan. 1965	Dec. 1966	Marcus H. Greifinger, Essex
	2 years	Jan. 1965	Dec. 1966	Luke A. Mulligan, Bergen
AMA Alternates:	2 years	Jan. 1965	Dec. 1966	F. Clyde Bowers, Morris
	2 years	Jan. 1965	Dec. 1966	John F. Kustrup, Mercer
	2 years	Jan. 1965	Dec. 1966	Frank J. Hughes, Camden
Delegates and Alternates to Other States:				
New York:				
Delegate	1 year	1965 Convention		William F. Costello, Morris
Alternate	1 year	1965 Convention		John W. Holland, Atlantic
Connecticut:				
Delegate	1 year	1965 Convention		Lloyd A. Hamilton, Hunterdon
Alternate	1 year	1965 Convention		Josiah C. McCracken, Atlantic
Administrative Councils:				
Legislation:				
3rd District	3 years	May 1964	May 1967	Leonard Rosenfeld, Hunterdon
6th Member	3 years	May 1964	May 1967	Nathan J. Plavin, Hudson
Medical Services:				
2nd District	3 years	May 1964	May 1967	Leonard Brown, Bergen
3rd District	3 years	May 1964	May 1967	Karl T. Franzoni, Mercer
Public Health:				
3rd District	3 years	May 1964	May 1967	Elmer J. Elias, Mercer
6th Member	3 years	May 1964	May 1967	Marion F. Kaletkowski, Passaic
Public Relations:				
3rd District	3 years	May 1964	May 1967	George E. Barbour, Somerset
6th Member	3 years	May 1964	May 1967	Norman K. Boudwin, Burlington
Standing Committees:				
Annual Meeting	3 years	May 1964	May 1967	Peter H. Marvel, Atlantic
Finance and Budget (from the House of Delegates)	3 years	May 1964	May 1967	Wayne H. Stewart*, Cape May
Medical Defense and Insurance	3 years	May 1964	May 1967	Daniel F. Featherston, Monmouth
Medical Education	3 years	May 1964	May 1967	John W. Nicholson, III, Burlington
Publication	3 years	May 1964	May 1967	C. Spencer Davison, Salem
Woman's Auxiliary Advisory	3 years	May 1964	May 1967	Edward M. Coe, Union

All nominees were unanimously elected to the designated offices for the terms indicated.

*After the close of the annual meeting, it was found that Dr. Stewart was not a member of the 1964 House of Delegates and was therefore ineligible for this post. In consequence, the Parliamentarian has ruled that Dr. Stewart's election is a nullity.

MEDICINE AND RELIGION

Monday, May 18, 1964, 3:30 p.m.

REVEREND DOCTOR PAUL B. MCCLEAVE, Director, Department of Medicine and Religion, American Medical Association, Chicago, Illinois

THE MOST REVEREND JOHN J. DOUGHERTY, Auxiliary Bishop of Newark; President, Seton Hall University, South Orange

DOCTOR ELY E. PILCHIK, Rabbi, Congregation B'nai Jeshurun, Newark

REVEREND CORNELIUS P. TROWBRIDGE, Chaplain, St. Luke's Hospital, New York, New York

DOCTOR JEROME G. KAUFMAN: Ladies and gentlemen: I want to welcome you on behalf of The Medical Society of New Jersey to this interesting program on Medicine and Religion.

About eleven months ago, at a meeting of the American Medical Association in this city, a similar meeting was held. This proved to be so interesting that I decided to organize a Committee on Medicine and Religion for our Society, feeling that it was very important.

About that time I met this very charming Presbyterian Minister from the South, who will moderate this program. He has helped me and guided me in the organization of the committee and of this important work in the medical structure of the State.

It therefore gives me great pleasure to turn this meeting over to Reverend McCleave.

(Applause)

THE MODERATOR: Thank you, Doctor Kaufman.

I'm very happy once again to be back in Atlantic City; for, as you well remember, it was on a Sunday evening of June 21st last year that the Department of Medicine and Religion of the American Medical Association announced that it was ready to participate with the state and county medical societies across the country in programs involving physician and clergy relations and conversation relative to patient care. I remember the evening in the auditorium here at the annual meeting, when Dr. Edward Rynearson of the Mayo Clinic and Bishop Fulton Sheen of New York were our two speakers.

You will be interested in knowing that, since that time, forty-five states have organized Committees on Medicine and Religion on the state level and over seven hundred county medical societies have begun the participation of the program of the physicians at the local area, inviting clergy to visit with them and discuss with them subjects and topics of deep concern of patient care. We are also recognizing that a new step is involved within us and that a number of state societies at this time have begun consideration of such a subject matter and program of the relationship of the two professions in patient care.

We are looking forward to San Francisco and the annual meeting, at which time Dr. William Menninger of the Menninger Clinic of Topeka, Kansas, Rabbi Abraham Herschel of New York City, and Dr. Edward R. Annis, President of AMA, will be the three speakers at a Medicine and Religion program on Sunday evening of the opening of the convention. There are many subjects and deep concerns that all of us have in the two professions of medicine and the clergy when we concern ourselves not with self but with someone else. It is a matter that we are professions of deep concern—concern of someone else. And whether this is a matter of life and death, whether it is a matter of a catastrophic illness, whether it is a tragic accident, or whether it is delving into medical, moral, cultural ethics—whatever the case may be, we do recognize that there is the human cry of need on the part of many. They turn to us, and here we seek to find an arm-in-arm relationship that under a particular circumstance and in a particular situation the two together might offer the finest towards total care and treatment. For, after all, illness is more than physical; illness can be emotional, it can be social, it can be spiritual. I'm quite certain that the parents of a retarded child are far more ill than is the child. And I am reminded of the fact that Dr. Rynearson told us in June last year that seventy-two per cent of the people that come to Mayo Clinic as patients are not organically or physically ill; but they are sick people. And

so there is a relationship, there is a need of this relationship; and this is the task that in medicine we are seeking to spread even into another area—or, shall we say, perhaps a return to the area of a closer relationship of the two professions for patient care.

One of the things that we might say, and particularly today, is that the panel is all clergy—and it's very fine that we do have such a distinguished panel as we have today. Your State is to be congratulated on the men who have been selected, not including the Moderator, of course. But since we are all clergy who are going to speak this afternoon, I might say to the physicians who are present that our task of the Department of Medicine and Religion is not to affect your personal spiritual life in any way. In other words, we are not going to make churchmen out of you. I, personally, am concerned, but not as a Department. We are not concerned in making all people one faith; we are concerned with recognizing a person's faith, and caring for and treating that person within that faith. It is a major task, a vital task, and the desire and the concern on the part of physicians across America; for this is something that is unbelievable in medicine, and particularly to me as a part of that Department that is so new. With these few introductory comments, and knowing very well that you know better than I the distinguished panel that has been selected by your state committee, Dr. Kaufman, I would like to introduce then for our first speaker of the afternoon—to speak in the area of the natural partnership for the total health of man—the philosophical basis for the partnership—the Most Reverend John J. Dougherty, Auxiliary Bishop of Newark: Bishop Dougherty.

(Applause)

MOST REVEREND JOHN J. DOUGHERTY: Thank you, Reverend Chairman.

Members of the Clergy, my dear friends, ladies and gentlemen: It is a truism that in contemporary medical practice the doctor must treat the whole man, that the distinction between functional and organic disorders is a theoretic rather than a practical one, a significant part of the composite; that is, the whole man is the factor of religion. There are varieties of religious confessions and degrees of religious commitments, but there is hardly a man alive who is not in some shape or form religious. If we include in this perspective such substitutes for religion as agnosticism and atheism, there is no man alive who is not somehow influenced by religion. It is the doctor's assignment to treat the living whole man, and recognition of the religious factor in the life of all living will contribute greatly to the benefit the doctor can render to suffering mankind. I am, therefore, reassured and pleased with the decision of the American Medical Association to establish a program of this kind in the Department of Medicine and Religion.

I recall that, on a visit to a hospital some years ago, I was requested to visit a woman who had lost her baby in childbirth. After I had spoken to her for a while, she said quite simply, "I wish doctors were also priests." Her words struck me and stayed with me. They were the foundation of a talk I later gave to doctors. I called the talk "The Priestliness of the Doctor." If you ask me to sum up the quality I call priestliness, I would say it is caring for the patient as a person; reading his heart as well as his chart. The significance of this meeting is the hope that the wish of that woman can be fulfiilled. Because of encounters like this between the medical and the clerical professions, patients may find more compassion in doctors. And with greater compassion, doctors will dispense greater healing and a greater peace. "It is a better thing to give than to receive." And when you give compassion and love to men as well as healing, you are indeed doing the better thing.

Doctors are also people and they are sometimes patients. My observations apply to them in their need as they do to the generality of men. Doctors are educated people, and therefore some things that are true of the generality of men are not true of them. Education's aim is to liberate men from the dark things of the mind—superstitution, irrationality, inordinate anxiety—and we must allow that it does achieve moderate success in this regard. Medicine is classified among the learned professions.

It has merited that distinction because of a long line of literate, learned, cultured humanists with degrees in medicine. It would, indeed, be lamentable if the present absorption with specialization and research were to deprive us of the social benefits of this profession's dedication to learning. A research profession is a poor substitute for a learned profession. I speak of learning as an opening to permit me to speak of wisdom. Wisdom is a word we associate with Solomon rather than with contemporary man. We may be able to do without the word; we cannot live without the thing. We need wise men today as never before. Now, while it is true that wisdom has been associated with learning as its handmaid, it is also true that both have been associated with religion. No one who can decipher hieroglyphic can forget that. Writing was once the exclusive property of the priests of Egypt. The point I wish to make is that there is an intimate association between learning and wisdom, and an intimate association between wisdom and religion. In fact, there is a whole section of the Old Testament described as wisdom literature. The inference I wish to draw is, that by means of this program, the clergy may render a service to doctors by providing deeper insights into the nature of religion, and by pointing out differences between authentic and spurious varieties of religious phenomena.

If religion is recognized as closely allied to wisdom, it must also be observed that it is closely allied to philosophy. Philosophy searches out things in their ultimate causes. What may philosophy say about the ultimate cause of religion? I propose that cause to be the very nature of man, and for the following reasons: The historical record of civilization covers about six thousand years, beginning with the ancient civilization of Sumer on the Persian Gulf and of Egypt on the Nile. From the beginning of the record up to the most recent line of recorded history, religion has been a consistent feature of mankind's experience. And in most of that history, it has been the dominant motif in man's experience. The period of man's experience before written records is known as prehistory. Relics of prehistoric man, such as burials and cave paintings, indicate the fact of religion in the experience of prehistoric man. To pass from the past to the present, studies of the subconscious seem to indicate that the idea of God is rooted deeply in the subconscious mind. Dr. C. G. Jung believes he had discovered correlations between dream patterns of his patients and certain elements of ancient religious mythodologies. This briefest of historical sketches is designed to be suggestive and provocative rather than apodictic. It may suffice to show that to observe the phenomenon of man is to behold the phenomenon of religion and, therefore, it is hardly the better part of learning or wisdom to dismiss religion as utterly irrelevant to any individual or group of individuals. The ultimate reason, therefore, for the existence of religion seems to be the nature of man, and a generic definition of it might be man's interpretation of human existence.

The interpretations of human existence as expressed in religious belief have been many and varied, taking such forms as Animism, Fetishism, Polytheism, to mention a few of the varieties of religion. Common to all the forms were two basic themes: deity and immortality. The history of religions shows a gradual purification of religious concepts culminating in the monotheistic religion of Moses and the philosophic monotheism of Aristotle, and a gradual ascent of conscience culminating in the writing prophets of the Old Testament and the revelation of Jesus. The evolutionary pattern observable in the physical world is also characteristic of the spiritual world. In addition, philosophers and theologians of Jewish and Christian persuasion admit a metaphysical or a transcendental factor is the development of religion; that is, Divine intervention. The long and complex history of religions does not invalidate religion any more than the long and complex story of biological evolution invalidates man. The significance of this, as I see it, is that contemporary man should not interpret his existence in insolation, but rather in the light of the total experience of mankind, and should recognize that as he carries in his body his biological past, so he may carry in his subconscious his spiritual past.

To affirm this is not to authenticate every religious manifestation as valid or even healthy. Religion's basic contribution to mankind is the addition of the dimension of invisible reality to the world of the visible, the invisible God and the invisible soul. This dimension is so universal that you will not encounter a patient without it, either in rational faith or in abnormal distortion, and the dimension in many, bright or dark, will have much to do with his health, I believe. I see no reason why spurious religious excrescenses should invalidate authentic religion any more than boils invalidate the circulatory system. Given the long and complex past of religion, and given its almost infinite contemporary variety, and given the turbulent condition of our planet, and given the increase of mental and emotional ills and instabilities, is it any wonder that religion wears ten thousand masks? The need is not to count and categorize the masks, or to dismiss the whole lot as obsolescent. The need is to distinguish the true face of religion from the false.

Religion, therefore, is not one clear, consistent pattern easily seen and readily apprehended. It is manifold and complex. It is for the intellectual and the illiterate, the wealthy and the poor, the healthy and the sick—it is hard to get away from! I think it is important for the doctor as well as for the minister, the rabbi, or the priest to recognize that what is for everybody cannot be the same for everybody. Freedom is for everybody in America, but it is not the same thing for everybody. A Sociologist, Gustave Mensching, has suggested that "The refined intellectualism of the great world religions is really too advanced for the great majority of people and that, therefore, there evolves a folk religion in which the elite theology and ethics of the world religions are diluted by pagan and semi-pagan popular superstitions and cults which are satisfying to the desires of the ordinary man for magic and gnosis."

An illustration of this would be the recurrent anxiety about the end of the world, upon which so many religions have been built in the past and the present. This sociological aspect of religion is similar to the irrational approach of certain groups to current political problems.

All of this has to do with the human condition. Religion does not exist in a vacuum. It stalks men's minds and haunts their hearts. It walks the boardwalk and the bowery. It can be denied, but it cannot be ignored. It inhabits the clinics and the private wards. It is not always clothed in "refined intellectualism." It is often an inarticulate cry, a thousand voiceless tears, or the desperate grip of a hand in cold sweat. Your instruments are aseptic, not your patients. You minister not only to sick men, but also to weak mankind. You may rid him of his virus before you rid him of his superstitition, but you may not thereby disdain him. Compassion is not only for the beautiful and the strong, not only for the intellectual elite. It is for the clean and the unclean, the naked and the poor, the dull and the disenchanted, even for fools.

This, you may say, is an idealistic humanism, something to be admired but hardly to be imitated—that it is for exceptional men, be they doctors or clergymen, not for the average man. True, it is a humanistic and a humanitarian ideal, for that is the gift of the great world religions to the world. But it is also the function of religion to motivate all men with an ideal, an ideal that their minds behold with joy and their hearts long for with hope; and it is the function of religion to provide us with the spiritual resources to follow the ideal by walking among our fellowmen with healing hands and healing words. To such men the world will point and say, "Behold the priestly doctors. How great are their powers of healing."

(Applause)

THE MODERATOR: Thank you very kindly, Bishop Dougherty.

To rid the virus does not necessarily sustain the man. We shall not forget this.

Our next speaker, will talk on the subject of "The Historical Character of the Partnership." It is my pleasure to introduce to you Doctor Ely E. Pilchik, Rabbi of Congregation B'nai Jeshurun of Newark and South Jersey: Rabbi Pilchik.

(Applause)

RABBI ELY E. PILCHIK: Thank you, Reverend McCleave.

Bishop Dougherty, Chaplain Trowbridge, and President Kaufman of this Association: The greatest Rabbi of the Middle Ages made an honest living ministering as a physician. His name was Doctor Moses Maimonides. The Arabs called him Abu Amram. He ministered at the court of the Sultan Saladin at Cairo from about 1175 until his death in 1205.

The Jews said of him: "From Moses, the lawgiver, unto Moses Maimonides, none has risen like unto him."

The Moslems said of him, as summarized by their poet Alsaid Ibn Sina:

"Galen's art heals only the body,
But Abu Amram's the body and soul;
With his wisdom he could heal the sickness of ignorance.
If the moon would but submit to his art,
He would deliver her of her spots at the time of full moon,
Cure her of her periodic defects,
And at the time of her conjunction save her from waning."

The Christians thought so much of him that their prime hero, Richard the Lion-hearted, sought to persuade him to take leave of his royal Saracen patient and to come back with the Great Crusader to England. But Maimonides stuck with the Sultan.

I say he was the greatest Rabbi of the Middle Ages. I devoted some seven years at my seminary studying his religious writings. I shall not burden you with his classical works on Jewish law and philosophy and ethics, but permit me to list here some of his writings in medicine:

A Commentary on Hippocrates
A Compendium on Galen
De Regimine Sanitatis
Notes on Dietetics
Notes on Sex Hygiene
A Treatise on Foods
A Treatise on Materia Medica
Sefer Hassamin—a Book on Toxicology
A Work on Hemorrhoids
A Work on Gout
A Work on Asthma
A Work on Mental Diseases
A Handbook on Treatment for Accidents and Emergencies.
De Causis et Indiciis Morborum—The Etiology and Pathology of Diseases.

Now, permit me to dig into the thought of Maimonides, the physician, a little deeper. It seems that his toughest patient was Al-Malik-al-Afdal, the eldest son of the Sultan Saladin—a spoiled brat who lived a frivolous, profligate life, and developed every conceivable ailment. For this heir to the throne Maimonides wrote in 1198 a booklet on the Rules of Health from which I quote:

"The emotions of the soul affect the body by producing significant and wide ranging changes in the state of health. Physicians therefore advise that the emotions of the soul be watched, regularly examined, and kept in proper balance. The physician should see to it that the sick and healthy alike be of cheerful disposition; emotions that cause upset and disorder should be smoothed out. This is essential for the cure of every patient, and especially for the care of mental cases like hypochondria and depression. The physician should apply no treatment before he removes the irritating condition. The physician should not consider the treatment of upset emotions a medical skill. It is rather a problem of practical philosophy and religious ethics. We find emotional affections of great intensity only in persons who have no notion of philosophical principles, of religious ethics, and of ethical teachings in general. Such persons are unbalanced and un-energetic. Distress and misfortune aggravate their trouble so that they scream and cry and strike their cheeks and chest. Some persons are so completely unnerved by misfortune that they die suddenly or soon after learning of it. Similarly, when such persons meet with good fortune, they become over-excited to such an extent that they die of an excess of joy. Those, however, who are conversant with religious and general ethics are only slightly exposed to extraneous influences."

So wrote Maimonides over 750 years ago.

In recent years, the late Dr. Carl G. Jung, to whom Bishop Dougherty referred, echoed this very thought. In one of Jung's papers on "Psychology and Religion" he says:

"Among all my patients in the second half of life—that is to say, over the age of 35—there has not been one whose problem in the last resort was not that of finding a religious outlook on life. It is safe to say that every one of them fell ill because he had lost what the living religions of every age have given to their followers, and none of them has really been healed who did not regain his religious outlook."

Medicine today knows a million times more about the human body today than Maimonides knew in the twelfth century, yet he established a fundamental and immutable truth—that the human body is a limb of the human soul.

I have chosen but a single example of the inextricable kinship between medicine and religion, though my subject is the historical background of this relationship. Maimonides, I believe, epitomizes this partnership. I chose him because I know him best. I could have reminded you of antiquity—of the priest-medicine man, of Imhotep in Egypt and Asklepeos in Greece. I could have taken you to the surgeon Paré, who concluded his operations with: "I have done my work; now it is

for God to heal." I could have reminded you of the great Paracidsus in the sixteenth century, who said: "All health and all diseases come from God, and in God is the cure. The physician is only a servant of God and works to accomplish His will. God acts through the instrumentality of man, and restores the sick to health through the instrumentality of the physician." I could turn back to the earliest days of this very Medical Society of New Jersey and name some of its clergyman-physician members. But let me confess that most of my life has been devoted to Jewish studies and only from them can I draw even the slightest claim of knowledge.

"I wound and I heal," says the Lord through Moses in Deuteronomy 32. Therefore, those who minister to health, in my religious tradition, are regarded as messengers of God and as the executors of His will to heal. So Maimonides regarded himself. Maimonides' son, Abraham, succeeded him as Chief Rabbi of Egypt and succeeded to his medical practice. Abraham's son, David, also fulfilled both roles. Indeed, all through the ages we have the combination of rabbi and doctor. In the last several centuries with the rise of categorization and specialization and, if you will forgive me, fragmentization, the two have split. Even so, the greatest doctors I've known in my lifetime are men of great spiritual faith. I shall never forget those weekly meetings in the home of one of America's most distinguished ophthalmologists, Dr. Harry Friedenwald of Baltimore, sitting with us and poring over Bible and Talmud in quest of some relevant religious truth with which he could help his patients.

In the long history of Jewish experience, clergyman and physician were frequently on. And when they were two, they stood side by side ministering to the patient, whose body and soul are one. Faith quickens the will of life. Medicine freshens the well of life.

There are, I have learned from Theodosius Dobzhansky, more than two million biological species now living on our little earth. Of all that vast and varied multiplicity man is but one. He is primate. He is mammal. He is vertebrate. His is a sexually reproducing multi-cellular animal. He shares DNA with the mouse and the minnow and the microbe. His arrangement of the four nucleotides is different. I think he differs from his biological kin in more, much more, than the four letters of the genetic alphabet. I think he differs not only in evolutionary degree but in evolutionary kind. I think that consciousness and self-awareness and his constant reaching out for purpose and meaning makes man something profoundly unique atop the biological scale. Being different, his well-being demands that different approach which welds the ministries of physician and clergyman.

Perhaps we can conclude this sampling of the historical union of religion and medicine for the health of man by returning to Moses Maimonides, who has been called the Sir William Osler of medieval medicine. Maimonides, some authorities believe, composed this variation on the Oath of Hippocrates—this physician's prayer:

"And now I turn to my calling:
Oh, stand by me, my God, in this truly important task!
Grant me success! For
Without Thy loving counsel and support,
Man can avail but naught,
Inspire me with a true love for this my art
And for Thy creatures.
Oh, grant—
That neither greed for gain, nor thirst for fame, nor vain ambition,
May interfere with my activity.
For these, I know, are enemies of Truth and Love of men,
And might beguile one in profession
From furthering the welfare of Thy creatures.
Oh strengthen me!
Grant energy into both body and the soul,
That I may e'er unhindered ready be
To mitigate the woes,
Sustain and help,
The sick and poor, the good and bad,
The enemy and friend.
Oh, let me e'er behold in the afflicted and the suffering,
Only the human being!"

(Applause)

THE MODERATOR: Thank you very kindly, Rabbi.

We will remember that—physician and clergy, the instruments through whom God works. As the third and final thought for our discussion this afternoon, "The Therapeutic Potential of the Partnership Both for the Individual and for Society," we have an individual who has spent much time in the hospital as a chaplain. We are pleased to

have with us Reverend Cornelius P. Trowbridge, who is the Chaplain at St. Luke's Hospital of New York City: Chaplain Trowbridge.

(Applause)

REVEREND CORNELIUS P. TROWBRIDGE: It isn't fair to ask anybody to succeed the two addresses that have just been made, and least of all myself. Fortunately, I have not come with any carefully prepared address such as the two that we have just listened to, and therefore I beg of you not to compare my presentation with those that have just preceded me.

As a matter of fact, I have a slight excuse. Bishop Stark, the Bishop of the Episcopal Diocese of Newark, was scheduled to be the third speaker on this program and had to give out only recently. I received a telegram when I was on a short vacation in New Orleans asking me if I would substitute for him, and I couldn't very well refuse; but since my return there hasn't been really the time to make the kind of preparation I would like to have made for this meeting.

The only asset that I perhaps possess is the fact, as Dr. McCleave indicated, that I probably see more sick people in the course of a year, in the course of a week, than anyone else in this room. I didn't mean that to be an insult or a joke; it was meant as a statement of fact, because naturally as a chaplain I see more patients than any doctor has the time to see in the course of his rounds. So I am at least familiar with the subject that we are discussing in a very personal way.

It is a great privilege to represent the clergy and the church in a hospital such as St. Luke's in New York, which is a hospital that has had a long tradition of just the sort of relationship that we are thinking about today—a relationship between clergy and the physician and surgeon. It was founded by Dr. Muhlenberg, who was an Episcopal clergyman in New York. He defined the hospital as a chapel surrounded by wards, and this is still literally true. As you come in the main entrance of St. Luke's Hospital, the first thing you see is the chaplain. This is symbolic, I think, of an attitude, of an atmosphere that we believe is of very great importance. For ninety years the hospital was administered by clergymen; not by a single one, but by a series of clergymen until it reached the point where it needed a trained administrator. At that point the Department of Religious Services, which I represent, was set up. So in that particular hospital we as chaplains—there are four of us there—are accepted as an integral part of the total healing ministry that is offered to patients by all of us, and it is a very warm and happy relationship. Many a time a doctor will stop me in the corridor and say, "I wish you'd go and see so and so"— one of his patients. "I think perhaps you can be of more help at this point than I can." This is not intended as a compliment to me in any degree; it just means that he recognizes that this patient needs the sort of ministry that we are qualified to exercise.

And I think this is growing in hospitals. You can testify to this better than I. In hospitals all over the country, as I see it, there are more and more demands being made for qualified chaplains to be part of the actual hospital family than there are chaplains to fulfill those posts.

Now, when we talk about the partnership between religion and medicine, we need to define very briefly, of course, what we mean by religion. If by religion is meant a faith that one who puts his trust in God is sure to have everything turn out just as he wants it to, or that prayer is a device by which we may persuade God to do something that He doesn't want to do, that is one type of religion which I don't think possesses very much potential for the individual or for Society.

But if we mean by religion the faith that is a commitment to God no matter what happens, come Hell or high water, for richer or poorer, for better or for worse, in sickness and in health, if that is the type of religion we are thinking about and if prayer, instead of being a device to persuade God to do something He doesn't want to do, is regarded as the way in which we can bring our wills into line with His will, then I believe that kind of religion possesses tremendous potential in this partnership about which we are thinking; and I hope I do not need to make it clear which type of religion I would try to represent.

I wish I could give you statistics, because I know that as scientists you like to have statistics, which would prove that religious faith helps people get well quicker or more completely than those who do not possess religious faith. About two years a very intelligent girl—and she should be intelligent because she was the granddaughter of Rabbi Wise— came to see us in the hospital with a questionnaire that she wanted us to fill out relating to the religious lives of the patients that we were seeing, or the lack of religion, and to try to make some estimate as to the effect that their religious faith had upon their stay in the hospital or their ultimate cure. She was going to make this study not only in St. Luke's but in a city hospital and in another hospital under Jewish auspices. We were very interested in trying to help her prepare this paper for Columbia, and we kept a pretty good record for her of a fairly large number of patients that we visited and turned them over. That's the very last we heard. And I'm so sorry, because this could have provided some type of material that might lend itself to statistical analysis.

Then there was a study made a few years ago of a group of patients who had ulcerated colitis, and they were divided into a group that were of religious persuasion and those who were not. But I am sorry to say that the results of that study seemed very indeterminate and didn't give us any real indication of the effect that religion could have upon patients. So all I can say is that in my own experience, both in parishes and now in the hospital, I am personally convinced that those who possess a real religious faith—I don't mean just a lip service type of thing—are far more likely to regain their total health than those who do not possess that kind of faith. This is simply my own personal testimony. Perhaps you, as you get the chance to ask questions or to make statements, can corroborate that view or disprove it, if you will.

I first learned this lesson the very first year of my ministry as a curate in a New York parish when I was sent to see a woman whose first name, strangely enough, was Faith. I was told before I went that her mother had died of terminal cancer, that she had nursed her mother through the whole illness, and that she was now dying of the same disease. So I went expecting to find a pathetic, dejected person, maybe filled with self-pity or bitterness or something of that sort. Instead, I found this radiant woman who wouldn't allow me to speak about herself or her illness; who just kept the conversation focused on me and my relation to the church. This taught me a lesson I've never forgotten. Faith can be a tremendous factor in the way in which illness is met, whether it ends in life or in death.

There is one place where I would like to differ with some of the doctors probably here, and that is in the reluctance, shall I say, on the part of many doctors to let their patients know the truth about their condition, thinking that if they did so these patients would turn up their toes and die all the sooner. My own feeling—and my own experience, such as it is —makes me convinced that many more people would like to know the truth than many doctors would say. There comes a certain sense of relief to a patient when he knows the whole story that is not there when the uncertainty still exists. And so in the discussion that is now to follow I hope perhaps someone will pick up that angle of my presentation and elaborate upon it.

It seems to me that the best thing I can do now for this meeting is to cut whatever time I have left short so that you may participate. I just want to conclude by saying this: the factors of fear, of guilt, of hate, of bitterness and resentment are all factors which we as clergy should be qualified to help patients overcome. And if those factors are removed from patients, you as physicians will have, I am sure, a much easier time in restoring them to health.

Thank you very much.

(Applause)

THE MODERATOR: Thank you, Chaplain Trowbridge.

For just a few moments, as our time has gone, we thought of the possibility of two or three questions that perhaps anyone would like to direct to any members of our panel. We will ask that the question be brief and not a

speech, please; and we will ask our panelists to speak pointedly to the question.

Are there questions from the floor that you might like to ask?

MRS. HENRY A. CHIEFFO (Hudson County): I looked around to see if anyone did want to speak. I don't belong to the Medical Society, but are the ladies allowed to ask questions?

THE MODERATOR: Yes, you may ask a question.

MRS. CHIEFFO: Thank you.

This has always been bothering me. At all the different lectures that I have attended on psychiatry and religion and mental health, why is it that the philosophy or the mental acuity of a communist is never referred to? The mental outlook or the philosophy of communism is never mentioned. Don't you think this has a great deal to do regarding mental health and religion?

BISHOP DOUGHERTY: They passed the ball to me.

MRS. CHIEFFO: I wish you would take that.

BISHOP DOUGHERTY: Of course, any talk that is given is obviously a compressed kind of thing. I have alluded to your point, not by specifying any specific group, but I consider communism to be what I call an ersatz religion. This can generate in a given individual, or a group of individuals, as much "faith" as an authentic religious experience can. And so I think as far as the effects are concerned—let us say, on his health and so forth—he is motivated by an ideal which, of course, is the classical society ideal. It's a goal, and if you have read about it you know it is described as a form of Meschinism. They have a hope, they have a goal, they have an objective for which some of them are willing to die. The point is, it doesn't have the dimension—what I consider the true dimension—of religion, which is, of course, the transcendental or the metaphysical or the supernatural. It doesn't have that. It's all limited to this world and to that classless society which you might say is almost as remote as Heaven.

THE MODERATOR: Thank you, Bishop. Is there another question?

DR. ROY T. FORSBERG (Union County): I have been interested in this field for a long time. I would like to ask you, and through you, if all the clergymen in their seminaries are getting improved pastoral care relationship studies. In other words, there has been for many years, I think, a real lack of communication between the physician of any faith with the clergyman of any faith. Many times the clergyman has been reticent to call upon us as physicians. But also I don't think that he has been trained adequately in ministering to the sick person in the hospital confines.

THE MODERATOR: To speak to that, Dr. Forsberg, would be this: I would say that in the last twenty years within many seminaries across the county there is a great movement that the clergy be given specific training in what we might call clinical pastoral care of the patient in the hospital, or the sick person within the home, or the sociological illness of a family. As compared to seminary teaching of some twenty or twenty-five years ago, there is a tremendous movement in this area. There is much yet to be desired. Perhaps in this regard it would be that when we think about our county medical programming here is the opportunity. Who better can inform the clergy of hospital courtesy, ethics, medical terminology, patient relationship than the physician himself; at the local level how opportune for a panel of physicians to explain many things of this nature to the clergy. For we have to remember, also, that one of the problems that you have as physicians with the clergy in the hospitals, I am sure, is the fact that there are clergy and there are clergy, as there are physicians and physicians. But also we must realize that there are a great number of clergymen in America who are not seminary graduates. Let me put it this way.

There are 134 hospitals across America today that are carrying out a program known as pastoral clinical training centers, and these hospitals invite clergy to attend. They run

programs of two, six, or eight weeks; three months; and some, even a year's internship where the clergy actually go to the hospital; they see the hospital endeavor; they are lectured to by physicians; they see the whole hospital procedure; they are schooled in counseling. These centers are available to clergy of all faiths. I am trying to find one in New Jersey, but you don't have it.

Because of the time—and I'm getting the word from the President—I wish to make one other comment before we close. I first wish to thank our panelists for the fine presentations which they have made. I hope that they will permit me to have these manuscripts; I would like to have them. We do thank you for taking your time from your busy schedules and being with us today at our state medical society meeting.

Where do we go from here? This is the philosophical, historic, actual therapeutic background of the idea of medicine and religion. We have known this. It needs to be called to our attention. And as Medicine, where do we go and what in some practicality can we accomplish that we desire to know?

Having been with this Department for two and a half years, I did not realize the sincerity and the desire on the part of you, as physicians, for the concerns that you have in this whole realm of thinking and the real honest desire to speak and to talk with clergy. The clergy across the country are standing ready for your invitation. They, too, are concerned and would like very much to sit with you in visitation.

Where do we go from here? Well, may I suggest that we need—and this is the purpose and the task of our Department—to prepare for you through your state committee program materials.

There are no answers; no—because every patient is different, even though the diagnosis is the same. Do you tell a man or don't you tell him that he is going to die? There is no direct answer, but we need to discuss it.

How do we approach this? What assistance actually can the clergyman be to the family, to the person of the patient that is yours?

Now that we are able to have wonder drugs and we can sustain and maintain life, you have a right as physicians to ask the paradoxical question "Why?" sometimes. The clergyman must understand and recognize that it's a theological question, because of the advances of medical science and knowledge and wonder drugs, to ask the paradoxical question, "Why?"

We need to recognize that today, because of medicine and all the things that we have and the hospital facilities and the knowledge that is ours, perhaps rehabilitation is becoming one of the most severe problems we have to face, and the physician cannot handle it from the office and the office alone.

Where does the place of the clergyman fit into this? I had it revealed to me so specifically lately. I use as an illustration the rehabilitation of John Glenn—a man of great physique, the finest body. Art Snyder of the Daily Sun Times of Chicago was one of the reporters in Houston, Texas, three weeks ago to see and talk with John Glenn when he came from the hospital. Medical science has done all that it possibly could for this man, and today he can't walk; today his head sticks out, and his hands jut out trying to find his balance. It takes more than a tranquilizer; it's going to take a lot.

What about the moral, medical, cultural ethics of transplant—of the heart-lung machine when it becomes as commonplace as the incubator in the hospital? How would you like to be on the committee of seven people in Seattle that makes the decision of who gets to be on the kidney machine?

These are things we need to talk about. This is the direction of our thought. And Medicine and Religion know today that if we don't do it, then perhaps the newspaper will do it for us. And Heaven help us if they direct the medical ethics.

We thank you for your attendance. We are glad you were here, and we look forward to things in New Jersey under the direction of President Kaufman.

(Applause)

(The meeting was then concluded at 4:50 p.m.)

MEDICAL-SURGICAL PLAN

Saturday, May 16, 1964, 4:15 p.m.

The open discussion on the Medical-Surgical Plan was convened at 4:15 p.m. Nicholas F. Alfano, M.D., President of Medical-Surgical Plan of New Jersey, presided.

DR. ALFANO: We meet together today in the shadow of sadness, occasioned by the recent loss of Medical-Surgical Plan's beloved leader, who was also one of New Jersey's most eminent physicians. Let us stand for a moment of silence in memory of Dr. Schaaf.

(Moment of Silence)

PRESIDENT KAUFMAN: This is an open meeting on the Medical-Surgical Plan. Discuss your problems freely. And now, I'm happy to turn the meeting over to my good friend, Dr. Alfano.

DR. ALFANO: Thank you, Dr. Kaufman.

This session marks the first Open Discussion on Medical-Surgical Plan in which Dr. Schaaf has not participated, either as presiding officer or by contributing of his wisdom and experience from the floor. His counsel, his energetic devotion to Blue Shield and to medicine, and his personal friendliness are sorely missed by all in Blue Shield and all in the medical profession. We who carry on the cause to which he gave so unstintingly of himself have dedicated ourselves to carrying forward his ideals.

Today's discussion will, I expect, deal largely with a problem that has concerned many of you, as it has concerned us: delays in payments. I would like to say a few words at this time about that situation.

Progress in any endeavor seldom follows a smooth upward curve. It is often hampered by complications, frustrations, undesirable adversities, and even retrogressions. Sometimes one step back is necessary before two steps ahead can be taken.

This has been true of the Plan's introduction of additional automated processes to keep records and pay claims. Hopefully, the end result will be a great improvement in processing claims and making payments. We are moving nearer to that almost every day. As the wheels of progress often grind slowly, the Plan, and the doctors having dealings with us, have had to experience some birth pains. It will take a while before all the problems are completely resolved. When we do reach the point that cumulative payments are being made every day to every doctor whose claims have been approved—and claims are being processed in a matter of only a few days—we will all be able to look back on the period of troubles as having been worth enduring.

A number of doctors have been seriously inconvenienced and many others have, understandably, been frustrated and annoyed. We are truly sorry for this—and believe me, we have experienced our own share of frustration and annoyance. Having embarked on this new processing technic, there is no turning back; we must continue to weather the storm as best we can. There has been one bright ray of light breaking through the clouds. It comes from the tolerance exhibited by the vast majority of doctors caught up in these problems. To them we say again, "We deeply appreciate your patience and understanding."

I wish I were able to tell you that patience and understanding were universal. Regretably, such is not the case. We were frankly surprised at the intolerant attitude expressed by a very few members of the profession. Despite repeated explanations of the problem and the fact that it was impossible to do anything about it, in many cases some of these individuals threatened us with law suits, invaded our offices with attorneys, wrote to the Department of Banking and Insurance demanding investigations, and to the Governor demanding some sort of action. One complainant even suggested that the President of this Society make a public denunciation of Blue Shield. These individuals chose to believe that the Plan was deliberately inconveniencing them, and that the problems could be solved by an official proclamation. Thus they exhibited considerable ignorance of, or disregard for, what Blue Shield is and how it operates. At the same time it might be inferred that they were experiencing an awareness, perhaps for the first time, of something

they had been taking for granted: the importance of Blue Shield to them.

The situation on claim processing and payments is improving steadily. It is not yet ideal, and if you experience further delays, please be tolerant and understand that progress has a price.

There is another matter to which I wish to call your attention. That is the Nationwide Blue Shield Test of Performance Survey, of which you have been notified this past week. This is not just a local project initiated by, or for the sole benefit of, Medical-Surgical Plan, or even of all the Blue Shield Plans collectively. Organized medicine has a large stake in this survey, because it will hold up a mirror to the effectiveness both locally and nationally of the voluntary health care system, as exemplified by organized medicine's Blue Shield mechanism.

Dr. Kaufman stated in a letter which gave Medical Society endorsement to the survey: "Our voluntary system will survive only if we document its strengths and find and correct any weaknesses. Each doctor included in the survey, therefore, can make a unique contribution by participating in this important project."

The mechanics of the survey are being well publicized to the profession, so I will touch only briefly upon them here.

A random sampling of recently-paid claims will be made. A questionnaire will be forwarded to the doctor on each case selected. The patient, the type of services rendered, and their dates all will be clearly identified to the doctor.

The doctor will be asked if he accepted the Blue Shield payment as payment in full for the covered services. If he did not, he will be asked the total fee charged, the reason for the additional charge, and what his charge would have been in the absence of Blue Shield coverage. He also will be asked two questions regarding his years in practice and type of his specialty. The questionnaire utilizes check-off boxes for most answers, and requires about one minute or less to complete. All information furnished by the doctor will be completely confidential. The portion of the form on which the doctor and patient are identified is torn off before the questionnaire is returned, in a postage-paid envelope, to National Association of Blue Shield Plans.

The information developed by this study will be of great value to Blue Shield collectively, and to individual plans, in appraising fee schedules, income limits, and types of contract in the light of today's medical economy. Thus it is of equal importance to organized medicine.

Since claims will be selected by random sampling, some doctors may receive more than one questionnaire, others may receive none. Doctors who treat patients enrolled in other Blue Shield Plans may also receive questionnaires from such other plans. It is of the utmost importance that all questionnaires be completed and returned, to make the survey effective—and this applies to participating and non-participating physicians alike.

The first batch of questionnaires will be mailed out June 1, the second batch about June 15, and the final batch about July 1. It will not be necessary to make further mailings if the required ratio of replies is received from the three scheduled mailings.

The final matter to which I will refer is another important one. The constitutionality of two sections of the Plan's Enabling Act have been under attack by Group Health Insurance of New Jersey. One section required approval of nominations as trustees of a medical service corporation by *a medical society of not less than 2,000 members.* This was declared unconstitutional by the New Jersey Supreme Court. Very soon now, the Court will rule on the other section at issue which requires 51 per cent participation by the eligible physicians in each county, in order for a medical service corporation to do business there. This is a matter of the gravest concern to the Plan and, we are certain, to all the members of the medical profession who believe in the Blue Shield concept and do not wish to see it rendered impotent.

We in Blue Shield are confident that whatever the Court's ruling may be, the medical profession in New Jersey will continue to give the cooperation and support that makes Blue Shield possible. We look to our participating physicians to continue to stand behind the Plan. And we would like to point out that an opportunity exists for physicians not now

participating to demonstrate their support of the voluntary system by signing up with the Plan. Blue Shield has been described as the last bulwark against the invasion of a socialized system of medical care. How strong a bulwark will remain depends upon those who are now counted in the ranks of Blue Shield, and those who can make it even stronger by joining.

Since participation is such a vital matter, and since Blue Shield's first obligation among the medical profession is to those physicians whose participation makes the Plan possible, I am going to ask each speaker from the floor to identify himself not only by name and county, but also as to whether he is or is not a participating physician.

Now I believe we are ready for questions.

DR. DEUTSCH: I'm Deutsch from Union County. I am a participating physician. Tell me: First, what has been your experience with the over age 65 program?

Second, I'm giving you a kudo, plus The Medical Society of New Jersey, for two programs we put into operation during a number of years past. Now one—ERA for those who were unable to pay for medical care during depression times, and then the Medical-Surgical Plan—has enunciated its basic philosophy to take care of the low income group. I just want to leave that right there.

How will you be able to participate in a voluntary program, if the report of the House Ways and Means Committee comes out in which they want to take care of the medically indigent under the age 65, plus those over age 65 within the current framework itself? Will you be able to participate in that on a subsidized basis?

DR. ALFANO: With respect to the first question, I cannot give you any statistics at this time as to the experience we have had with our senior citizens' contracts. The contract has not been in force a sufficient time to have experience emerge which would be able to indicate to us as to whether the contract is being utilized properly, over-utilized, or what. Blue Cross and Blue Shield issued the senior citizens' contract simultaneously. There has not been sufficient emergence of experience (and in the recent rate application there was no change in the Blue Cross senior citizens' contract), so we are not in a position as yet to know what our experience will be under the senior citizens' contract.

Even though there have been two offerings for the senior citizens' contract—that is, the special age 65 contract—we have not had more than 6,000 applications approved for that program, so we do not have too many people enrolled under the special senior citizens' contract.

As to the second question: I don't think that whatever legislation may be adopted by the federal government, at least at this time, it will not involve physicians' services. As you know, the King-Anderson type of legislation that has been contemplated over the past several years deals solely with hospitalization. I have no doubt that once the government subsidizes hospitalization for age 65 and over, it won't be very long before they will be making approaches to also covering the physicians' services.

DR. DEUTSCH: You answered that very, very well. I was anticipating one step further. In case this does come up to the Senate, of course they will make a few changes in this bill trying to make it agreeable to the Administration on their Medicare proposal and the King-Anderson Bill. Senators Javits and Keating of New York plus some other Republican senators have come out with a bill in which medical care will also be furnished outside of the hospital. That's what I was leading up to: could a voluntary insurance plan partake in that under a subsidized basis if they wanted to keep it on a voluntary basis?

DR. ALFANO: It depends again on the type that is eventually adopted. One kind of legislation would provide indigents with a sum of money to purchase voluntary health insurance. We would be able to accept that type of insurance where the subscriber or the individual himself would have the choice as to the type of coverage he wishes, whether it be the Blue Plans, whether it be commercial or otherwise.

We have no idea as yet as to what will be the eventual legislation, if at all. I don't know how we would cope with the situation. We would have to play it by ear and determine

what we could do at the time such legislation is adopted and gear ourselves to the best type of coverage possible under the circumstances.

DR. FISHKOFF: I am Alexander Fishkoff from Middlesex County. I am a participating physician. I represent a small segment of doctors who are not participating, certain specialties included particularly, wherein they are interested in one subject matter which I have brought up before at many times. This concerns the third-party liability multiple insurances. What has come of that? Some years ago this was brought up on the floor, resolution, and presented to the Medical-Surgical Plan for consideration. Nothing has yet been concluded.

DR. ALFANO: The Plan has not been unmindful of the desirable changes that have been requested repeatedly by many physicians throughout the State. A number of physicians have approached us on the possibility of making some arrangements where third-party liability exists that a participating physician would not be held to the payment provided by the Plan as full payment when a judgment or award to his patient may exceed the income limits. Let us use that as a base. Where the award may be $10,000 or more, the doctor feels as though he is being discriminated against as a participating physician when he must accept Blue Shield payment as full payment when in many instances the amount of the award by the court depends upon the information provided by the physician himself. Last November, we again approached the Commissioner of Banking and Insurance. He reiterated what we have been told many times: that he will *not* consider any provision in the contracts where, when third-party liabiilty exists, a participating physician would be given the opportunity to charge that patient additionally. We asked whether we could have such an arrangement where there was multiple or major medical insurance. He would *not* approve any contract in which we included provisions of that nature; and that is the answer, Dr. Fishkoff.

DR. FISHKOFF: In other words, we must look to the Legislature to make some changes. Now, let's come to the next question—a reiteration of the meaning of *participating* physician versus the so-called service benefits accruing to an injured or a sick person who is a member of the Plan insofar as the income ceiling is concerned. Recently, I had a call from the president of a union. He bluntly stated that he would not go along with the request from the Medical-Surgical Plan by having a member of his union supply the Plan with a copy of the W-2 income tax withholding form. In this situation, the husband and wife were working. I felt that their income was about $7500, and naturally I looked to them for the additional payment between my regular fee and the fee that was paid to me by the Plan. Apparently, he didn't want to have a precedent set in complying with this request. I brought to his attention the fact that as a means test I'm involved in this, too, as a participating physician.

DR. ALFANO: When we have a situation of the nature you described and when a physician feels that the subscriber withheld the information concerning income, we write to the subscriber and ask that he provide us with the necessary information for a determination as to whether he comes within the contract provisions for service benefits. On occasion, when we have been refused such information, we had informed the subscriber that the Plan could not then prevent a participating physician from charging an additional amount.

When we have taken such a procedure into consideration we have had the approval of legal counsel that where we cannot get the income information when it's been requested, we then tell the subscriber that he is liable for the additional amount.

DR. FISHKOFF: May I make a correction in your statements, because I want it to be known that we are not asking for additional payment above our regular fee? In your description you refer to "additional payment" or "additional fee." It's not an additional fee; it's an increased amount above what Medical-Surgical pays to supply us with our regular total amount due us. Otherwise, people get the wrong impression. This is what happened with this particular union president. We have had quite a few discussions on this, and he is angered by the impressions that all his men received. He said, "We are going to negotiate

a new contract with another insurance company."

DR. ALFANO: I'm sorry, Dr. Fishkoff. When I mentioned additional fee, I meant the additional fee over the limited payment made by Blue Shield.

DR. FISHKOFF: I know what you meant, but I just wanted the statement so it will not be questioned.

Let us come to another matter, the matter of Rider "J" and also where there is payment for accidental injury insofar as the maximum payment is concerned: the maximum payment of $50, I believe, for out-patient or office treatment. This needs more realistic clarification, especially when related to in-patient hospital treatment versus that in the operating room. Payments for procedures in the operating room under general anesthesia are the same as in-patient or out-patient; rather, or office under local care, under local anesthesia. There is no discrimination between payment made under those instances.

For example, those of us who do traumatic work in a hospital found that we get the same fee if we do a case in the operating room under a general anesthesia, with all its implications, with all the time consumed in preparing and post-operative care, as in a procedure of the same type in the emergency room when it comes to doing, we'll say, a lacerated wound. There is no differential there. That needs further clarification.

DR. ALFANO: In that instance perhaps we need a lower schedule for services rendered outside of a hospital for the same service.

DR. FISHKOFF: Don't make it lower than that because it's low enough as it is, unless you eliminate that altogether from the Plan.

The payment for wound repairs is not realistically or practically applied. The inadequacy of payment is a deterrent to incentive in these cases compared with scheduled procedures. Some patients are alert and understanding and aware of this. Most often patients are critical of the doctor in matters of this sort. But I have a letter I'd like to read. A copy was sent to me of what was sent to the Plan. I'm only going to a read a portion of it because I have received in the past letters of the opposite type. This tickled my heart, and I think some of you will feel the same way. This was addressed to the Hospital Service Plan, which they meant by the Medical-Surgical Plan:

"Our four-year-old son fell and hit the raw metal end of a frame. His lip was severely lacerated, one tooth was cracked, and his chin cut open. The pediatrician met us at the hospital, but upon seeing the severity of the laceration immediately recommended a specialist who could do a plastic repair. Thereupon, Dr. Fishkoff was called in. For nearly two hours this man labored over the delicate work of placing sutures in a small lip, some twenty-five in all. This was not a simple procedure, and it could not have been done by just anyone.

"I feel he did a commendable work and was not out of line in submitting the bill he did. In the past we have been well satisfied with the service we received from the Blue Cross and Blue Shield Plan. This was indeed a disappointment, since we feel it was a justifiable bill and we find nothing in our contract which would indicate anything less than the entire amount being paid."

Is there any answer to this at all?

DR. ALFANO: Well, of course, I don't know what the Plan paid you.

DR. FISHKOFF: It isn't a question of amounts, just the principle of the thing, indicating that there are people who are aware of the inadequacies under certain conditions and they'd like to see the doctor get paid accordingly.

DR. ALFANO: A few moments ago I alluded to a new contract that had been under consideration in respect to third-party liability. The Plan Fee Committee has had under consideration for the past two years a revision of the schedule of payments and the Board has approved, in principle, recommendations that have been made by the Fee Committee to bring our fees up to a more realistic amount and taking into consideration the rising economy.

Our payments at the present time, in the main were determined and applied to the 1956 subscription contract which is yet in effect. The rate structure of this contract had taken into consideration the schedule of payments to be applicable to the 1956 contract. We are limited in the changes or the increases in fees that we can make under the contract, because our rates would not be able to stand up. We have so much money, and we can't exceed in benefits an amount which would exceed the money that the Plan has available. In many instances we have been forced to deny additional payments in areas where we

felt they were merited. But inasmuch as we are limited to a certain amount of money, we must abide by the schedule as it is currently in effect.

DR. FISHKOFF: In our office we are concerned with this, because we do quite a bit of work where there is Blue Shield or other insurance. We handle quite a bit of these cases. I refer to eye injury work. I say this advisedly and without prejudice by name, even though I may sound prejudiced—the arbitrary way in which this is handled. Revisitations for an eye injury case and the allowances in payment for re-visits are not consistent. This fee of three dollars is paid per visit and the patient told this is payment in full. This is *not* spelled out in the contract and confuses the patient where prolonged care is required and goes beyond the $50 allowance. Then the participating physician can charge his regular fee for the office. Now, this is the concept that the medical administration staff has arbitrarily concluded—I'm speaking about the staff in the Medical-Surgical office—for subsequent visits. Perhaps it is wiser to eliminate this portion of the follow-up care at all times and not apply it as it may suit the examiner, because this is what I have found to be so.

There is need for closer cooperation between the various county committees with the Medical-Surgical administrative and medical service personnel.

Many members of the unions are not happy in instances where the union officials take an arbitrary position not favorably disposed towards the Plan. I have had discussions in the past with various members. I do a good public relations business of my own. I do what I can, but I'd like to get further cooperation on the more definite plan of procedure with the county because I have found that very few counties participate as I, as an individual, have been doing myself.

I just asked your office recently if a meeting had been called with the county representatives of the Medical-Surgical Plan during the past year and the answer was no, unless I'm in error.

DR. ALFANO: We get from time to time requests by different specialty groups for conferences with the Plan to discuss various matters concerning the Plan, whether they be schedules of payments or general provisions or what have you. I have no recollection of any instance where the Plan has ever refused a conference with any medical group that has requested it. And actually we have given such representatives an opportunity to appear before our Fee Committee, which is composed of practicing physicians; they are members of the Board who have been designated as members of a fee committee. They have sat through a whole evening discussing, with whatever specialty group desires a conference with the Plan, matters that were of concern to them, until there was a meeting of the minds.

DR. SAMUEL J. LLOYD (Mercer—Participating Physician): You have said that the Supreme Court had determined that it was no longer necessary that Blue Shield have approval of its Board of Trustees; and has invalidated the part of the enabling act that covered approval of the Board of Trustees by a medical society of 2,000 members or over. Nevertheless, as a Delegate, we see in our work to be done that we are going to act on the approval of a member of the Board. I think for the benefit of the Delegates that you ought to point out why this is still being done and point out the advantages that Blue Shield feels they still have by such an association.

DR. ALFANO: Thank you for reminding me of that, Dr. Lloyd.

Notwithstanding the fact that the Supreme Court has ruled the subject provision as unconstitutional, the Plan nevertheless has continued to maintain that provision in its Bylaws. Our own Bylaws contain a provision that nominees to the Board must have the prior approval of the Medical Society before that nominee may be elected to membership. We need the close cooperation of the physicians, and I think that if you have noticed any of our advertisements in the last few months, you are seeing the stress we have played upon participating physicians.

Stated briefly, there would not be a Blue Shield Plan were it not for participating physicians. Our basic philosophy is to provide service benefits, and we need the cooperation

of a majority of our physicians to participate in such a program in order to maintain a Blue Shield philosophy and a Blue Shield organization.

This is not in any way an attempt to flaunt the Supreme Court with the fact that, despite its ruling, we still continue to include a provision in our Bylaws which they have ruled unconstitutional in the law. Nevertheless, there is a difference. The difference is that they have ruled it unconstitutional insofar as the Medical Service Corporation being able to receive a certificate of authorization. They felt that the certificate of authorization should not depend upon that particular provision. I believe our reason for withholding or maintaining such a provision in our Bylaws is entirely different.

Mr. Vanderbilt, would you want to add anything to that? Mr. Vanderbilt is our Blue Shield counsel.

MR. VANDERBILT: The legal distinction applies to the act under which Blue Shield operates. It's not just an act for Blue Shield only; you can have any number of medical service corporations. By declaring this one provision unconstitutional, the Supreme Court means that such a corporation is now *not* compelled to seek the approval of the nominations by the medical society or recognized by a medical society of over 2000 members. That does not prohibit Blue Shield on its own, through its Bylaws, from seeking such approval by the Medical Society. If another corporation is started in New Jersey, it would be up to them as to whether they wanted their nominations approved.

DR. E. MILTON STAUB: Dr. Staub from Union County. Non-participating. Why cannot the Blue Shield still be in operation in an indemnity plan rather than an all-inclusive service plan method?

DR. ALFANO: We have with us one of the founders of the Plan here today—Dr. Sprague. And I have often heard our Board say that if we were to go down the road as an indemnity plan, then we have no right to be in business. The only distinguishing feature about Blue Shield is its *service*. There are sufficient and excellent commercial companies who provide health coverage on an indemnity basis. We would certainly not be conforming to the principle that was established during the early years when the Plan was founded, that we were to provide a *service* plan, a full payment feature for the low income subscriber; and I doubt whether the Board would continue the Blue Shield Plan if we were to go down the road to providing indemnity rather than service. Were we to do that, it would not be long before we would be asked to reconsider or resign from the national organization. The national organization has, at the present time, indemnity plans; but year after year the pressure has been put on these indemnity plans to change to a service basis. And I just couldn't see the approval by our Board of the consideration that the Plan be an indemnity rather than a service plan.

DR. STAUB: One hestitates to put one's head on the block, but I was one of those that helped to establish the Medical-Surgical Plan of New Jersey. I am very much in favor of helping people with limited incomes. Perhaps our community is somewhat different than the communities of some of my colleagues here, but twice I was insulted by the Medical-Surgical Plan when people having a total family income greater than that which was covered by the service plans had business with me, and we agreed on a certain fee. It was satisfactory. But the patient (not the doctor) received a letter stating "your doctor is charging you too much." This, of course, was rather startling after we had discussed the problem ahead of time.

Many people have such a wide variety of and multiple insurances; they may have four or five. Even today I frequently fill out insurance forms which are in excess of my regular fee, and yet my regular fee still stands and the patient profits by the procedure that they had.

In our community I make this my policy: I say I am not a participating member. It is not my desire to remove a medical ill and leave a financial ill in its wake. My charge is a fee which is all-inclusive, including the preliminary examination, the surgical procedure, and the after-care until you are well; or for a period of six weeks or six months, whatever the case may be. If the difference

between what you have in insurance and what my charge is is difficult for you to meet, kindly let me know because I am desirous of helping you. This has always worked out. I have had no trouble, and this is one reason why I'm not a participating member.

Many times I have had people, (when I have charged the regular rate) say: "Is this all? Aren't you going to send in an additional bill?" And after an experience like this, one hesitates to be a participating member when being a non-participating members makes no difference in the rate he receives.

DR. ALFANO: I referred to the matter of attempting to rectify the situation where multiple coverage exists. We just don't get anywhere in our negotiations with the Banking and Insurance Department when we approach them on that matter.

What is of great concern to me, however, is the type of letter you cited that has been sent out by the Plan to the subscriber, that you charged the patient too much. Perhaps a letter of that nature will get out sometimes. We can't control all of the minutest details of a Plan operation. But I assure you were we to be informed of such a situation, the proper action would be taken with the individual concerned.

And the other statement, well, I think that perhaps this may be confusing in the minds of many physicians. There are many plans which, in citing their fee for a procedure, also include a specified period of after-care which is included in that fee. Thus, many physicians may be confused. But it has always been the policy in New Jersey that payment for hospitalization (whether it be medical care or surgical care) includes only the services rendered during such hospitalization. There is one exception to that, of course, and that's in obstetrics. As a matter of fact, the Medicare program here in New Jersey includes specified days or weeks which are included in the payment made for a particular procedure. New Jersey Blue Shield has never included such care as all-inclusive in the payment we make for the surgical procedure. The subscribers have been told of that; they have accepted it. Unions have been told of that and have accepted it, because it's been the procedure here since the Plan was initiated that the doctor—whether he be participating or not makes no difference—can charge for whatever care the patient requires following hospitalization.

DR. ROBERT R. AMBROSE: I'm Robert Ambrose from Somerset County, a participating physician.

I'm a general practitioner primarily, although I do some surgery. I want to bring up the question of medical service payments in surgical cases. Until recently the general practitioner took care of a case in a hospital and he got paid for the medical services rendered up to the day of operation. Now, that has been changed. Now, if a general practitioner takes care of a case that eventually comes to surgery and he assists at the surgery, he cannot be paid for both. He renders one or the other service free. Is that correct?

DR. ALFANO: No. If the assistant surgeon also rendered the pre-operative care, we will deal with him as we do the surgeon. We will pay him for whatever eligible pre-operative care is rendered prior to the 48 hours before the date of surgery. He is not paid, in other words, up to the day of surgery as we would a physician who did not participate in the surgical care of the patient. We will treat the assistant as we do the surgeon. He is paid for any pre-operative care that may be rendered up to 48 hours preceding the day of surgery.

DR. AMBROSE: How about a surgeon who takes care of a case with, say, multiple injuries for a couple weeks and then finds out he has to do major surgery on the same case, would he be covered for medical services for daily care up to the point of surgery?

DR. ALFANO: Up to 48 hours prior to the day of surgery.

DR. AMBROSE: I misunderstood. Thank you.

DR. ALFANO: If there are no further questions, I thank you, ladies and gentlemen, for coming to this meeting.

(Meeting concluded at 5:10 p.m.)

DINNER DANCE

Monday Evening, May 18, 1964

The speakers' section of the program was convened at 9:00 p.m. Mr. Richard I. Nevin was Toastmaster.

THE TOASTMASTER: Ladies and gentlemen: This dinner-dance in honor of President and Mrs. Jerome G. Kaufman is under the auspices of the Woman's Auxiliary. It now is my pleasure to introduce Mrs. Walter S. Booth, president of The Woman's Auxiliary, who will welcome you to this gathering. Mrs. Booth. (Applause)

MRS. WALTER S. BOOTH: Mr. Toastmaster, President and Mrs. Kaufman, honored guests, members and guests of the Woman's Auxiliary and of The Medical Society of New Jersey:

In behalf of The Woman's Auxiliary, it is my happy privilege to welcome you this evening to the dinner-dance in honor of Doctor and Mrs. Jerome Kaufman. We congratulate and honor Doctor Kaufman and his beloved wife on the completion of a strenuous and successful year.

We of the Auxiliary are deeply grateful to The Medical Society, and we speak with pride when we tell our auxiliary neighbors of your fine encouragement and financial support. The Auxiliary stands ready to support and to assist the Medical Society at all times. We want to share in your plans and in your programs. We want to help with the Medical Student Loan Fund, and we did well this year. We assist with the AMA-ERF Program. We work for scholarships and health careers. Our safety program reached more than a hundred thousand people this year. Each county auxiliary sponsors one or more public relations programs. These are received with appreciation by the public.

We are happy to say that, with the help of some wonderful doctors from Morris County, we were able to form a new Auxiliary there. We are happy to welcome our twentieth Auxiliary. The eligible doctors' wives have met, have elected their officers, and are ready for the next year.

We have assisted with legislation. We are justifiably proud of our officers, chairmen, and members for their excellent performance. They have been the liaison group between the medical profession and the public.

Doctor and Mrs. Kaufman, we wish you continued success and the best of health. Though your term is ended, we know that your interest will remain. We wish to make this a gala evening, one that you will long remember—a memorable occasion. To each and every one a most pleasant evening.

(Applause)

THE TOASTMASTER: Ladies and gentlemen: Now that you have met one another and have met with and dealt with the entrée, I'd like you to meet the guests at the head table. (Introductions)

THE TOASTMASTER: Ladies and gentlemen: I know I have been addressing you back and forth in the course of the evening so far. This is my official contact with you, not as general announcer but as Toastmaster.

I don't know how it is with you people, but I'm alway glad to live through this dinner. Sometimes conventions can be so hectic that it seems that a month ago it was almost a remote realization. And so, after this long day of preparing reference committee reports and dealing with the business of the Society, having emptied our minds of their prosaic concerns, we have all followed our hearts to this place of delight.

With all these flags flying, I cannot help thinking that, transported by imagination, tonight we are in the shadows of the battlements of Camelot.

I have had more farewell tours as Toastmaster, I think, than Madame Schumann-Heink. I shall always be glad to come up for one last tour, and I hope I won't know exactly when it is the last tour.

Very many years ago when I was listening to a radio set on the top floor of my mother's home—when I should have been doing homework and she didn't know I had the set working with earphones—I heard the broadcast of a dinner at which Charles M. Schwab

was receiving a citation from the United States Steel Institute as being the most valuable man of the year in the industry. Schwab in receiving the award said: "I have no idea what I did to merit this, but", he said, "some years ago I was in Paris at the close of World War I and I saw standing on the corner of one of the boulevards a French officer whose chest was so bedecked with medals and decorations that I wondered how he managed to stand upright. And I went up to him and said, 'I beg your pardon, sir. Would you mind telling me what you did to earn all those decorations?'

"He said, 'Of course, not.' And he pointed to the first decoration on his chest and said, 'You see this decoration? That was the first decoration I got, and that was given to me by mistake; and as a consequence of my having received that, I was given all the others.' "

(Laughter)

I'm delighted with the original mistake, and I hope it doesn't bother you too much.

It is my privilege, which I mean to take advantage of, to say something about the man whom tonight we honor. You know, you never call him—at least we never called him—Doctor Kaufman or Jerome G. or anything like that. It's always been Jerry. It just seems to be sort of natural with the kind of person that he is. When we were working together in preparation for his inaugural address, I said, "What are you going to put into it?"

He said, "I don't care much about anything else as long as we stress the point that a good doctor should deliver more than medical care—a good deal of love to his patients." That indicated his character and his worth to me.

Then I went over to visit his office for the first time and discovered that his suite in the building in which his offices are is "B-9." I thought that was indicative. *(Laughter)* And I have found him consistently benign, sincere, industrious, generous, compassionate, dependable, and loving. I have been reminded, working with him through the year, that we are urged as children of God to love one another; and I've always felt that there is implicit for all of us another unuttered admonition there: that if we are to love one another, we are also obliged as individuals to make ourselves lovable to one another. This I have found in Jerry. It is characteristic of people who are lovable and loving that they are loved in return, and that is why we followed our hearts here tonight . . . " and deep within his kindly heart," to paraphrase Kilmer, "are flames of love that lightly burn; he has of Heaven's gift a part, who loves and is beloved in turn."

I have been mindful of the fact that this is my old friend Will Shakespeare's four hundredth anniversary of his birth. We are warming up to the two hundredth anniversary of our birth. With this in mind I turned to Shakespeare to see what he might say of our guest of honor and his lovely lady tonight, and I found he said this:

When he shall die,
Take him and cut him out in little stars,
And he will make the face of heaven so fine
That all the world will be in love with night,
and pay no worship to the garish day.

Of Maola he said:

The hand that hath made
you fair hath made you good.

And of both he said:

He is the half part of a blessed man,
Left to be finished by such as she;
And she a fair divided excellence,
Whose fulness of perfection lies in him.

Ladies and gentlemen, I can't compete with Shakespeare. I withdraw. *(Applause)*

It is now my privilege to present Dr. Louis S. Wegryn, our immediate past-president—who is getting more immediately past-president—to present the Fellow's Key to our present president but potentially immediate past-president —Jerome G. Kaufman. Dr. Wegryn.

(Applause)

DR. LOUIS S. WEGRYN: Mr. Toastmaster, Honorable Justice Weintraub, ladies and gentlemen: It is indeed an honor and privilege to present to you, Jerry, this Fellow's Key in the name of The Medical Society of New Jersey. In my estimation, and in the estimation of our Fellows, you are the most deserving for working in behalf of the Medical Society for over twenty-two years. Congratulations, Jerry.

(Applause)

THE TOASTMASTER: Before we will permit Jerry to do what he wants to do, we want him—while his feelings are high—to present the Fellowette's Pin to Mrs. Walter Booth, who is retiring as president of the Woman's Auxiliary.

PRESIDENT KAUFMAN: Mrs. Booth, it is my pleasure and privilege to present you this Fellowette's Pin for the wonderful year as president of The Woman's Auxiliary to The Medical Society of New Jersey. I am especially happy to do that because of our personal friendship. They might as well know that it started at an airport a few years ago, when we were in line waiting for a plane. I didn't know you and you didn't know me, but we traveled together wherever we were. Good luck.

(Applause)

THE TOASTMASTER: The lady insists that she be pinned, Jerry. I think you should kiss her, too.

Dr. Arthur Bernstein of Beth Israel Hospital has requested the privilege of presenting a gift from the staff of Beth Israel Hospital.

DR. ARTHUR BERNSTEIN: Mr. Toastmaster, honored guests, ladies and gentlemen, and Jerry: It is my pleasure tonight to represent the medical staff of the Newark Beth Israel Hospital. They wanted to take this occasion to tell you of their great love and their great respect for you. They have presented you tonight with a desk set which they hope you will use for many years, on which there is a plaque on which is inscribed the following:

"Presented to Jerome G. Kaufman, M.D., by the Medical Staff of the Newark Beth Israel Hospital, in recognition of his outstanding services to the medical community as President of The Medical Society of New Jersey—1963-64."

And I'm sure, Jerry, that these same sentiments are held by every person in this hall and every doctor in New Jersey.

(Applause)

PRESIDENT KAUFMAN: Thank you, Arthur.

Arthur Bernstein flew in from Japan and Australia Friday morning about three o'clock and came down with this gift. I'd also appreciate his taking it home for me because it's pretty heavy. *(Laughter)*

Mr. Toastmaster, Mr. Chief Justice, honored guests, members of The Medical Society of New Jersey, members of The Woman's Auxiliary to The Medical Society of New Jersey, and my dear friends:

Within twenty-four hours I will pass the gavel to my dear friend, Charley Calvin, who will assume the presidency of this great organization for the year 1964-1965. I know tomorrow afternoon I will do this with mixed emotions; perhaps glad and happy that some of the load of responsibility will be removed, sad at the thought of many things I will miss. Now that my accountant has told me that for the next few years I can use the short form—*(Laughter)* and they tell me that I have many fences to mend when I get home—I really don't want to go home.

I will miss the great friendship, the warm reception, the cordiality given to Maola and me in our tour through the State and wherever we went through the United States. We did a bit of traveling. I covered about twenty-five thousand miles in New Jersey and a little more to the West Coast three or four times, Chicago, Pennsylvania, and so forth. Every moment of it was enjoyable; it was no hardship, believe me. But the time comes when you have to give up this post, so I will have to do it gladly. I'll miss, too, the chicken dinners and green peas three or four nights in a row, but the job wasn't too bad.

I'll miss coming home very late at night. I live on a very narow street, in a half sunken gable house, which some people can't find with light, and if I miss that turn, I go through, because—you may not know the town I live in—Short Hills is mapped out very peculiarly. If you look at the map of Short Hills, you cannot find one single straight street, and if you get off the course you are finished. I understand that our Treasurer, who was introduced to you tonight, once drove through Short Hills and was looking for a street known as Quaker Road, which is very difficult to find. After a half hour he hollered for help. But that I'll miss, too; and I'll miss many, many other things.

No one can say and no one can leave the position of presidency of this great organization without feeling that it is something to miss, and those who haven't gone through this have really missed something. All the hardships are nothing compared with the rewards which you have.

I'd like now, since this is your evening of fun, not to continue this speech. I want to thank the Woman's Auxiliary for giving Mrs. Kaufman and me this wonderful evening.

I want to thank Mr. Nevin, Executive Director —my Toastmaster—for the hundreds of favors he did during the year. He was a father; he was a brother; as a matter of fact, he gave me elocution lessons. *(Laughter)* And I'll never forget that the word "president" has three syllables. *(Laughter)* These are the things that Dick Nevin does for you. He had a hot line between Newark and Trenton long before Jack Kennedy and Khruschev ever thought about it. It's a wonderful experience, and I can never forget Dick Nevin for what he did for me . . . Never. He is a wonderful friend, a terrific Executive Director, and a great asset to this organization.

I want to mention something about Mrs. Edith Madden, our Convention Manager for many years, with whom I worked as chairman of the Annual Meeting Committee for some nine or ten years, and who is ill and couldn't be with us tonight. We all miss her, and we know she will be back with us soon.

And not to use a cliché, but someone has jumped in her shoes and did a terrific job here, and I'd like her to take a bow—Mrs. Marion Walton. *(Applause)* This is a terrific convention to run, and I know it. I was worried, very frankly. I kept bothering Mr. Nevin, and he said, "Don't worry. Everything will be taken care of." And everything was. This is a tribute to you, Marion.

I want to thank Miss Terrie Goeke, Mr. Nevin's Executive Assistant, for her help during the year. *(Applause)*

I can't go through the whole list of the staff, but the entire staff—Mr. Lambert and all the girls in the office—gave me a warm reception every time I walked in there. They were cooperative; they did anything I wanted; and they were a wonderful group.

And now to finish, let me introduce to you three members of my family who are here tonight: my sister Molly; *(Applause)* my sister-in-law, Mrs. Harry Kaufman; *(Applause)* her son and my nephew, Morton Kaufman. *(Applause)*

I can't sit down without saying something about my dear wife. She stood by this wonderful year and never said, "Slow down"; never said, "You can't do this." Though I didn't take her with me, when I came in late she was waiting for me. Maola, you know I thank you. Thank you. *(Applause)*

THE TOASTMASTER: And now, ladies and gentlemen, I have the honor of calling upon a distinguished lawyer, an eminent jurist, most important this evening, a dear friend of Jerry's —the Honorable Joseph Weintraub, Chief Justice of the Supreme Court of the United States. Well, perhaps I'm tipping my mit. That had to do with Camelot. *(Laughter)* All right, if you insist—just Chief Justice of the Supreme Court of New Jersey.

(Applause)

HONORABLE JOSEPH WEINTRAUB: Mr. Toastmaster, Dr. Jerry, Maola, distinguished guests, ladies and gentlemen: I can accept one-fiftieth of that introduction. That's enough. *(Laughter)*

I'm happy to be here to join with you in congratulating and felicitating Jerry and his lovely Maola. The very air, the very warmth of this gathering is testimony to which words can add very little.

When Jerry asked me to come down here and talk, I said: You know, Jerry, I'm in a position where there is very little I can talk about. After all, the position I'm in— this question and that, and others you are performing—it's very hard to talk without having something you said thrown back at you. Through the corner of my eye, I can see that your stenographer is very busy. But I told him of a story that Dory Kalisch, whom many of you know, told me just about a month ago. He was checking some old files, and he found a

letter from Mayor Raymond. I don't know how many of you remember him; he was Mayor of Newark. Raymond, writing to Dory Kalisch, spoke about a Justice of the old Supreme Court, also now departed. He said of that rather stuffy fellow, "You know, the only thing he would talk about is his posterior because he knows it will never come before him." *(Laughter)* So you see, I'm very much restricted in topic. And kicking around for something—I was just really sparring for time—I said, Well, let's call it "Medicine and Law." That really covers a lot and says nothing.

Actually, as I have been thinking about Jerry and his role as Mister Citizen, I suppose "Medicine and Law" is just about as apt a description as you can get of Jerry and his career, because he has been more than a doctor. He is a fellow who has interested himself in so many of the civic problems while, as will appear in my remarks, he has really been working side by side with us.

Now, when you doctors—and there are many of you here who have undertaken to work on one segment or another of me—usually start off by telling me what to expect, I really think that's a very fair thing to do. So let me say to you that what I have here will take about ten minutes, and it won't hurt very much. *(Laughter)*

Webster's Dictionary tells us this about the three learned professions: It's the name often used for the professions of theology, law, and medicine. And in speaking of these learned professions, Dean Roscoe Pound points to these sentences: *Organization*—you really represent that right here—the pursuit of a learned art, and a spirit of public service. And he stresses *making a living*—Jerry, I heard what you said about that short form—he said that making a living, which may be the main or sole purpose in other callings, can be but incidental to the profession. Now, though it is incidental, it of course is not irrelevant. There is no thought that a physician or lawyer is at his very best when he is faint with hunger. But what is meant is that we must move above an artifice and that the duty is to serve the public that inheres in the profession and in the exclusive franchise to practice the profession which the state bestows upon us. The compensation of the professional man is more than the worldly receipts. It includes the good feeling a selfish man can never know and includes also the esteem of his fellowman.

And in this area you doctors really do very well—and much better than your brethren at the bar. You hold this title of doctor, whereas all that the lawyer can expect to get is an abbreviation of that little known word "Esquire." And occasionally a judge will address him as "Counsellor", but really it's only because the judge doesn't want to acknowledge that he doesn't know his name. *(Laughter)*

So that you people may know how tall stands a doctor in my family, let me tell you that when my mother learned of my appointment to my present office, she thought for a moment, shrugged her shoulders with an air of resignation, and said, "Well, I always wanted a doctor." *(Laughter)*

One of the members of the Essex County Bar who was assigned to defend an indigent criminal, and defended him with lack of success, received a letter from this prisoner in State's Prison. The letter read something like this: "After reading the transcript of the trial, I see there that after your name is the word 'Esquire' and after the name of the Prosecutor I see the word 'Esquire.' Now, that means to me that you are members of the same club, and that's pretty hard to beat." *(Laughter)* And he said: "I'll be waiting for your answer." *(Laughter)*

Well, I thought I would speak very briefly, but if I don't follow this text—I don't think I will. Anyone who wants to read it can come up later. *(Laughter)*

We fellows are engaged in making law; frankly, we are. Some of my legislative brethren speak ill of it, but really when we decide a case, we make law because we've got to give an answer: yes or no; and whatever the answer, it's the rule. But after all, when we make law we are just trying to find the common sense answer. That is law. And to get it we need the facts, because facts yield the common sense answer. It is in this area where law and medicine meet that I would

hope that the two professions would get together and work together to the end that we would make in my position, my brethren on the court, fewer mistakes.

Now, what I mean, for example is this—this is Jerry's field and Arthur Bernstein's. Let's take, for example, the area of heart attacks in Workmen's Compensation. I promise you, ladies, I'm not going to take very long. But at one time we adhered to the rule that Workmen's Compensation would be paid only if there was evidence of some unusual stress or unusual strain in the work job. Analytically that was wrong, because the single question should be whether that work effort, usual or not, extraordinary or not, in fact did play a substantial role in bringing about the attack. And adhering to or yielding to the logic of it, we not so long ago changed the rule to hold that if any work effort, usual or not, in fact contributed in a substantial way there would be recovery. And now I'm beginning to wonder whether we assumed something we ought not to have assumed; namely, that the doctors could tell us whether ordinary work effort did contribute. I have a feeling now that perhaps we have driven you fellows into an area of sheer guesswork. If we have, then we are wrong. We should have adhered to the old rule, not because theoretically it is sound, because it is not as a theoretical proposition; but rather because as a practical matter we don't have the tools with which to take another approach.

We have had all kinds of questions come into court which ultimately get back to medical opinion. I think I shocked some of my brethren once when, instead of going to the books and reading and not knowing who the author was or whether what he said represented the views of the majority of you fellows or just one strange fellow, I actually called three psychiatrists on the phone—men in whom I have great confidence—to tell me as a practical matter "does this work or doesn't it?" I think I've learned more, as irregular as that might be, in finding out what you fellows can't tell us to help us in doing the job we must do.

Now, there are so many areas. You take the topic of criminal responsibility: insanity in relation to crime. Harsh things have been said about the law, but I have a feeling that we need better means of communication within our professions to the end that each would know what the other is really talking about, if each of us would understand and start with a common understanding of the problem. While I'm convinced that we do not have enough insight to solve the riddle of responsibility, I do feel that if we talk to each other, we probably would arrive at least at an agreement as to what we can do now with the limited amount of knowledge that we have.

And so with narcotics. We know that our approach to the handling of a narcotic offender is very dismal. But we really can't legislate, we can't decide what to do until we can find out from the medical profession what can be done for the addict, because it's only in the light of what you can do that we can reach an intelligent answer.

And so it seems to me that if we had better lines of communication, more ways of saying to you fellows "Here is our problem. What do you know? What can you tell us?"—perhaps asking for the society to give us a little brief upon the facts, I think we would do a better job. Let me illustrate two areas in which I think a very fine job is now being done.

We have a panel of medical experts, a cooperative effort between the Medical Society and the Supreme Court to set up a panel to whom we can turn for an expert to resolve disputes among other doctors, to the end that personal injury litigation can be disposed of fairly.

There is another area where Jerry has been active: the work now being done with the Director of Motor Vehicles to help him set up standards of ability for driving. This is the kind of thing that the two professions should do in discharge of their duty to the public because, after all, we are licensed to one end—to serve the public. So much for that. Now I want to go to another topic.

We have been having you fellows take a look at us, but lately we have had to take a little

bit of a look at you. Of course, in the natural sequence of events, you get the last look at us. The third profession has the last look at both of us.

But what I want to talk about was this relationship among you doctors, and with your Society and the hospitals. In speaking about this, I am not talking about any case that may now be in litigation or any one case that has been there. I think there are some kicking around. But I simply want to ask that you think about it in the light of purely your own interest, because no man is really free unless he has confidence that no matter what he does he will be dealt with fairly. That's the essence of a really free man. Now, we all would like to cling to familiar ways. It's kind of painful to change; but change we must, or be left behind.

One time a man could roar along in his surrey with scarcely a threat to anyone. Today a pedestrian may injure another by a thoughtless step. The closer we are, the more numerous we are, the more do we restrain the movements of each other. As our economic order becomes more complex and our economic lives more interdependent, the less can be our freedom to do as we please. The common law said, with great simplicity, no man may so exercise his rights as to interfere unreasonably with another's. That little Golden Rule means that we've got to make readjustments as new circumstances increase the capacity of one man to interfere with another. And so if an organization, whatever its origin, in fact so controls an area of activity as to interfere unreasonably with the opportunity of a man to pursue his calling or profession, an adjustment must be made. And it doesn't matter that the organization never sought the power to control the welfare of another. That power, however acquired, itself generates the responsibility to use it with due respect for the rights of others. And in making the adjustment we must remember that the professional license is granted to serve the public good; and the public good means, of course, that the patient is a party in interest.

Now it seems to me that the doctors ought to be able to resolve these problems themselves, because they, more than anyone else, know the facts; and the facts yield the answers, and it is always better that a solution be reached by those who will live with it. And that you can decide these matters is attested by no less a figure than Oliver Wendell Holmes, Senior—I must emphasize that it's the physician-poet, not the Justice—but he still very aptly said this: The lawyers are the cleverest men; the ministers are the most learned; and the doctors are the most sensible.

But if perchance you don't resolve them and you need our help, give us the facts and we'll do the best we can for you. If the answers we give you should seem not to be quite correct, please remember the story of the two clergymen who debated at great length the merits of their creeds with, of course, no common agreement. Finally one said to the other: "Well, after all, we're both trying to do God's will—you in your way and I in His." *(Laughter and applause)*

Ladies and gentlemen, it's really a great pleasure to be here and to say to Jerry, and more to Maola, a job very well done! Thank you.

(Applause)

PRESIDENT KAUFMAN: In my hurry to shorten the little talk that I gave you, I committed a great sin. To run your office while you are president-elect and president you have to have a staff that can develop beyond a fabrication; a staff which can do things for you when you are not around. I have been very fortunate, particularly this year, in having girls who were so well trained by me and by themselves that one day in my hurrying out from the office I heard one of the girls say, "They're paging Dr. Kildaire for surgery. He won't be there."

So at this time I would like to introduce to you, first my secretary who is with us tonight—Mrs. Axt. *(Applause)*

And then there is also one of my technicians here—Mrs. Schechman. Please take a bow. *(Applause)*

Much credit for the year must go to these two girls. Thank you.

(Applause)

(Concluded at 9:30 p.m.)

BOOK REVIEWS

Fundamentals of Voluntary Health Care. Edited by George de Huszar. Caldwell, Idaho, 1962, The Caxton Printers, Ltd. Pp. 457. ($6)

A large literature on the economics of health care already exists. Most such books and pamphlets either present a balanced, two-sided view; or they urge publicly-sponsored or government-operated plans. The text under review, however, is unique in that, in Mr. deHuszar's words, "It does not pretend to present both sides." It is, frankly, a collection of essays, stressing the values of voluntary, as opposed to compulsory or governmental, plans. Twenty-nine authors have contributed chapters. Some of the authors are physicians, some are economists, pastors, insurance experts, journalists, and so on. The text covers the moral, economic, political, social, and biologic aspects of the problem. It considers basic issues historically, economically, and ethically. It offers a veritable one-volume library of books and pamphlets presenting eloquently the case against socialized medicine. If it only had had an index, it would have been an indispensable reference work, source book, and manual for medico-economic speakers. Ulysses M. Frank, M.D.

Gynecologic and Obstetric Pathology. By Edmund R. Novak, M.D. and J. Donald Woodruff, M.D. Ed. 5. Philadelphia, 1962, Saunders. Pp. 713. 761 (31 in color) illustrations. ($16.00)

The latest edition of Dr. Novak's classic is larger, more complete, and in many ways more interesting than any that have preceded it. The first thirty-one chapters are essentially the basic volume, brought up to date by the editors. The descriptions and photographs are excellent, with some restrained but highly informative clinical remarks throughout. The authors are obviously experienced gynecologists besides being gynecological pathologists.

Three chapters are contributed by Dr. Nesbitt. These are very complete and exceptionally well written. The chapter on "Fertilization, Implantation and Placentation" has a narrative quality that is most unusual in a didactic work.

Dr. Frost's material on gynecologic and obstetric cytopathology is full of the latest information on this highly technical subject, and offers a view into the future uses of this exciting modality.

In a volume as attractive and well printed as this, it is surprising to find an unfinished sentence at the bottom of page 510. Some proofreader goofed.

This is an important book, a landmark in its field; and it belongs in the center of any complete shelf of gynecologic and obstetric literature. Percy L. Smith, M.D.

Preventive Pediatrics. By Paul A. Harper, M.D. New York, 1962, Appleton-Century-Crofts. Pp. 798. ($14.95)

This book emphasizes what heretofore has been inadequately taught to the pediatrician who discovers that the critical and diagnostic problems he was fully equipped to handle do not cover the major portion of his practice.

Dr. Harper, in this book, describes beautifully how a pediatrician can mold his practice to the "new pediatrics." The everyday problems of growth and behavior from infancy through adolescence, the common orthopedic problems, development of mind and personality, indications for and limitations of psychometric tests, the tonsil and adenoid controversy—all of these are discussed impartially and with finesse. He stresses the problems of the infant with low birth weight, nutritional requirements, and feeding aspects of infancy and childhood. He gives an up-to-date account of immunizations.

Other textbooks of pediatrics educate the physician in pediatric disease and the subspecialities. Dr. Harper, on the other hand, emphasizes problems of communication (vision, hearing, speech, reading, spelling, and writing disabilities), mental retardation (which he han-

dles adeptly in counselling parents), and other handicaps (cardiac, cleft palate, epilepsy, cerebral palsy). The reader is told about community, state, and federal services for children of all means—where to seek help for the handicapped child, how he may be educated, and preparation for his employment. Public health services (including prenatal programs, programs for the newborn, child health conferences, school health services) are discussed. Social aspects of medicine—such as juvenile delinquency, adoption, accidents, family planning and population growth—are given due consideration.

Dr. Harper comments on an issue which is not generally adhered to in private practice—that of the mother meeting the pediatrician *before* her baby is born and discussing questions of concern to her. This interesting point bears more investigation in collaboration with the obstetrician.

I recommend this book highly to pediatricians and to any doctor who cares for children, whether in medical centers, private practice, or public health work. It does not take the place of, but belongs on the shelf next to, general textbooks of pediatrics. If every pediatrician practiced what Dr. Harper writes, he would truly be giving total child care as is needed in modern pediatrics. Milton Prystowsky, M.D.

Practical Anesthesiology. By Joseph F. Artusio, M.D. and Valentino D. B. Mazzia, M.D. St. Louis, 1962, Mosby. Pp. 318. 28 figures. ($7.75)

A more appropriate title could not have been selected to indicate the substance of this most timely and interesting text. Practical details essential to proper everyday practice are considered in carefully arranged groupings. The book begins with basic aspects of anatomy, physiology, and pharmacology. Next pre-anesthetic evaluation, preparation, and premedication are presented. Sections are devoted to anesthetic principles of management and technics of administration. Also included are special considerations—such as fires, explosions, complications, monitoring, cardiac resuscitation, post-anesthetic care, medicolegal aspects, and research in anesthesiology. Lists of books for suggested reading are offered at the end of each chapter.

This book is designed for medical students and general practitioners as a handbook of current practices. Consequently, the technics of administration of halothane, chloroform, and methoxyflurane are omitted, since they are not considered the safest agents available for use by those who only occasionally administer anesthesia. Also, there is no consideration of methods of regional anesthetic in this text.

After perusing this volume, many students will be attracted to the specialty of anesthesiology; physicians already doing part-time anesthesia will certainly be inspired to advance their knowledge and training in this field.

Joseph Anthony Cox, M.D.

Correlative Neuroanatomy and Functional Neurology. By Joseph G. Chusid, M.D. and Joseph McDonald, M.D. Los Altos, California, 1962, Lange Medical Publications. Soft cover. Pp. 384. Ed. 2. Illustrated. ($5.50)

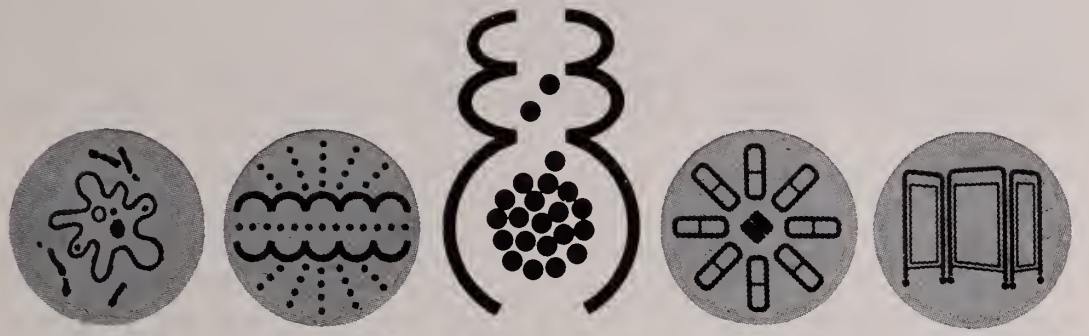
Soft-covered medical books are such a good idea that it is a wonder more publishers haven't followed Lange in developing these biennial editions at modest prices. Ten previous editions attest to the popularity of this manual. It is a basic text of the anatomy and physiology of the central and peripheral nervous system. Although the authors make no claims to having written a textbook of neurology, actually they do include compact diagnostic and treatment suggestions. The book is well illustrated with photographs and with many superior schematic diagrams. Also to be found a brief, but fully usable, outline of neurologic examination methods and tabulations of developmental levels. Other features include material on charting progress in rehabilitation, on low back pain, aphasia, electro-encephalography, headache, embryology, head injuries, syncope, and the autonomic nervous system. All in all this is one of the simplest, handiest, and least expensive reference works available on the subject.

Abraham Leff, M.D.

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The relatively few conditions in which Lomotil has given less than satisfactory control have been, for the most part, those such as severe ulcerative colitis in which too little anatomic or functional capacity of the intestines remains for the motility-lowering action of Lomotil to have effect.

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The recommended initial adult dosage is two tablets (2.5 mg. each) three or four times daily, reduced to meet the requirements of each patient as soon as the diarrhea is controlled. Maintenance dosage may be as low as two tablets daily. *Children's* daily dosage (in divided doses) varies from 3 mg. for a child of 3 to 6 months to 10 mg. for one 8 to 12 years of age. Lomotil is an exempt narcotic; its abuse liability is low and comparable to that of codeine. Recommended dosages should not be exceeded. Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness and insomnia. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates. Lomotil is a brand of diphenoxylate hydrochloride with atropine sulfate; the subtherapeutic amount of atropine is added to discourage deliberate overdosage.

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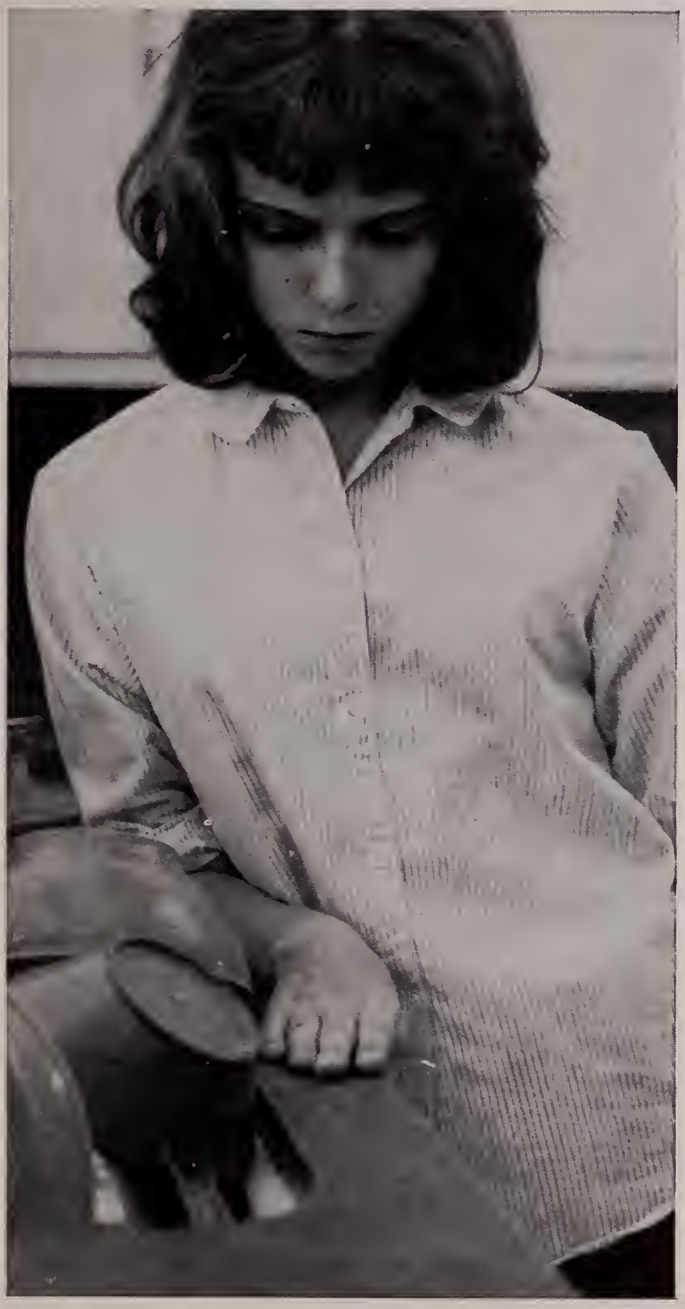
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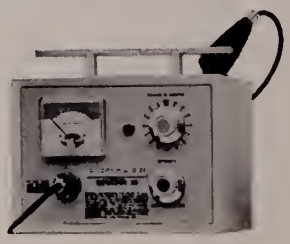
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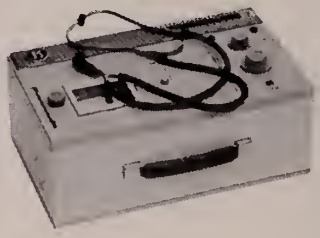
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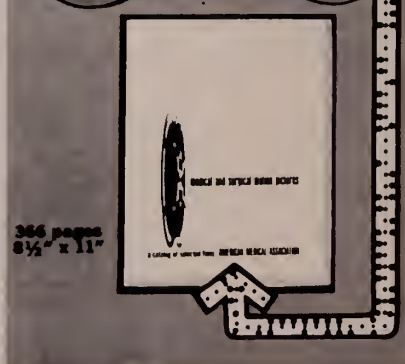
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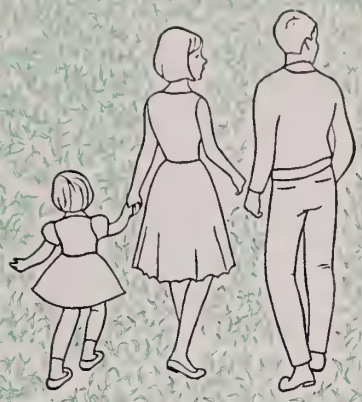
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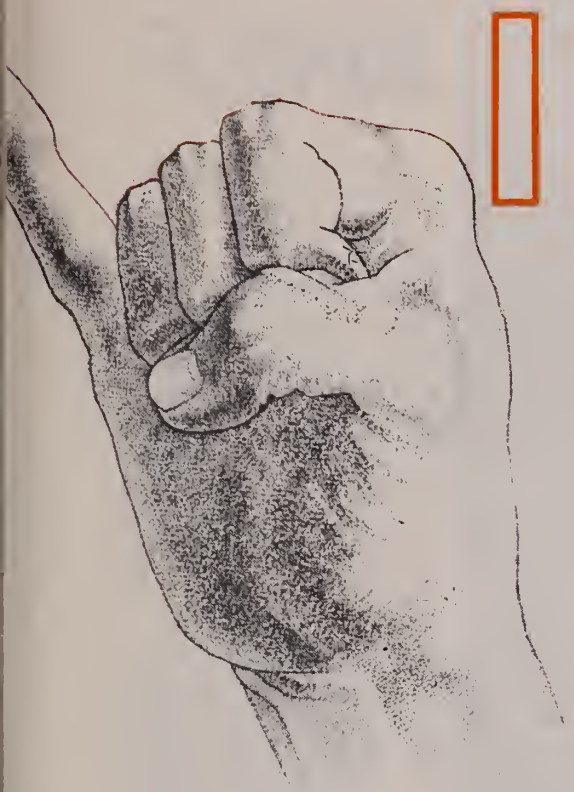
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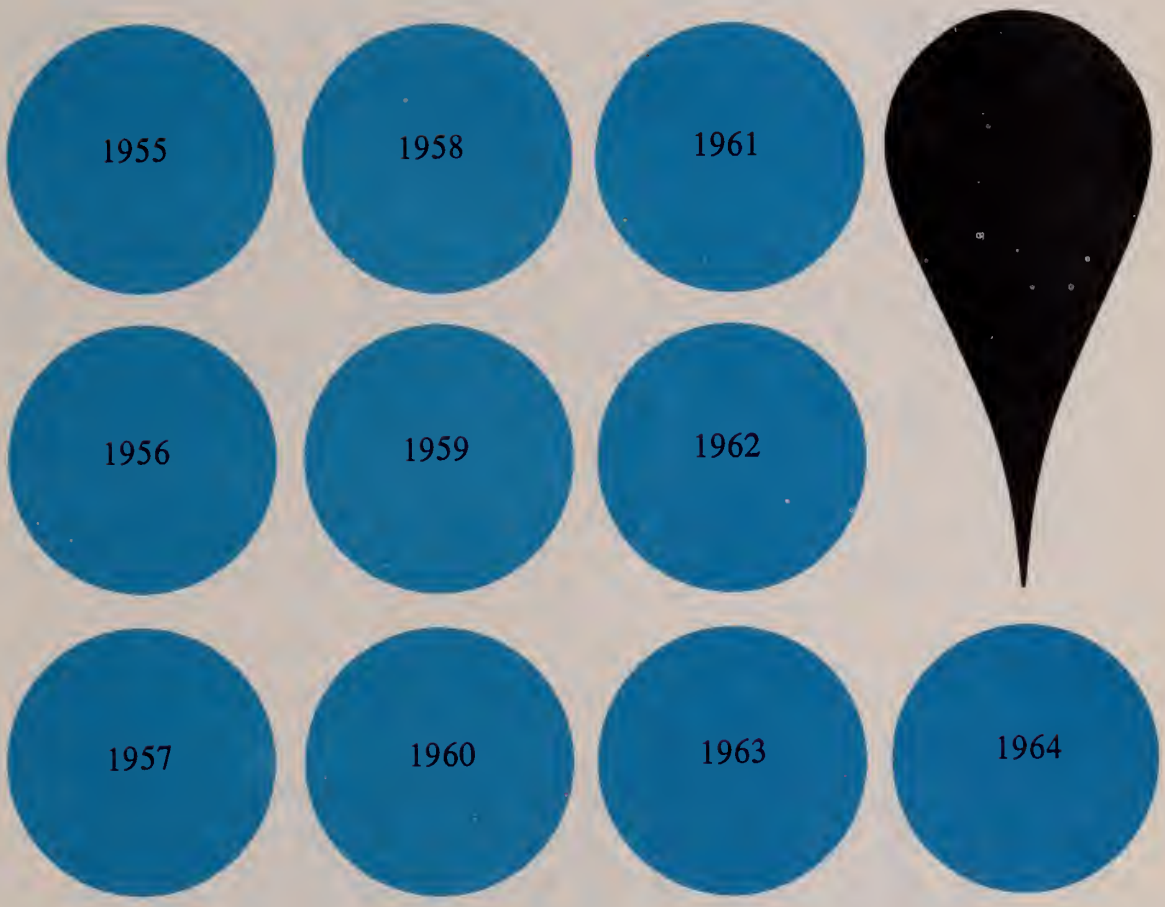
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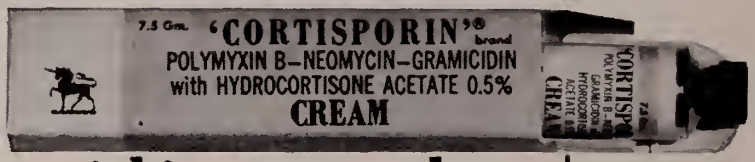
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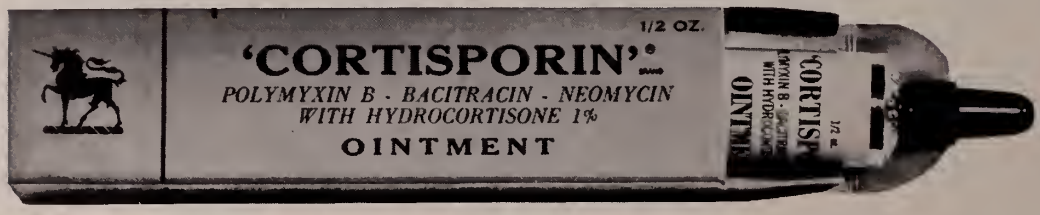
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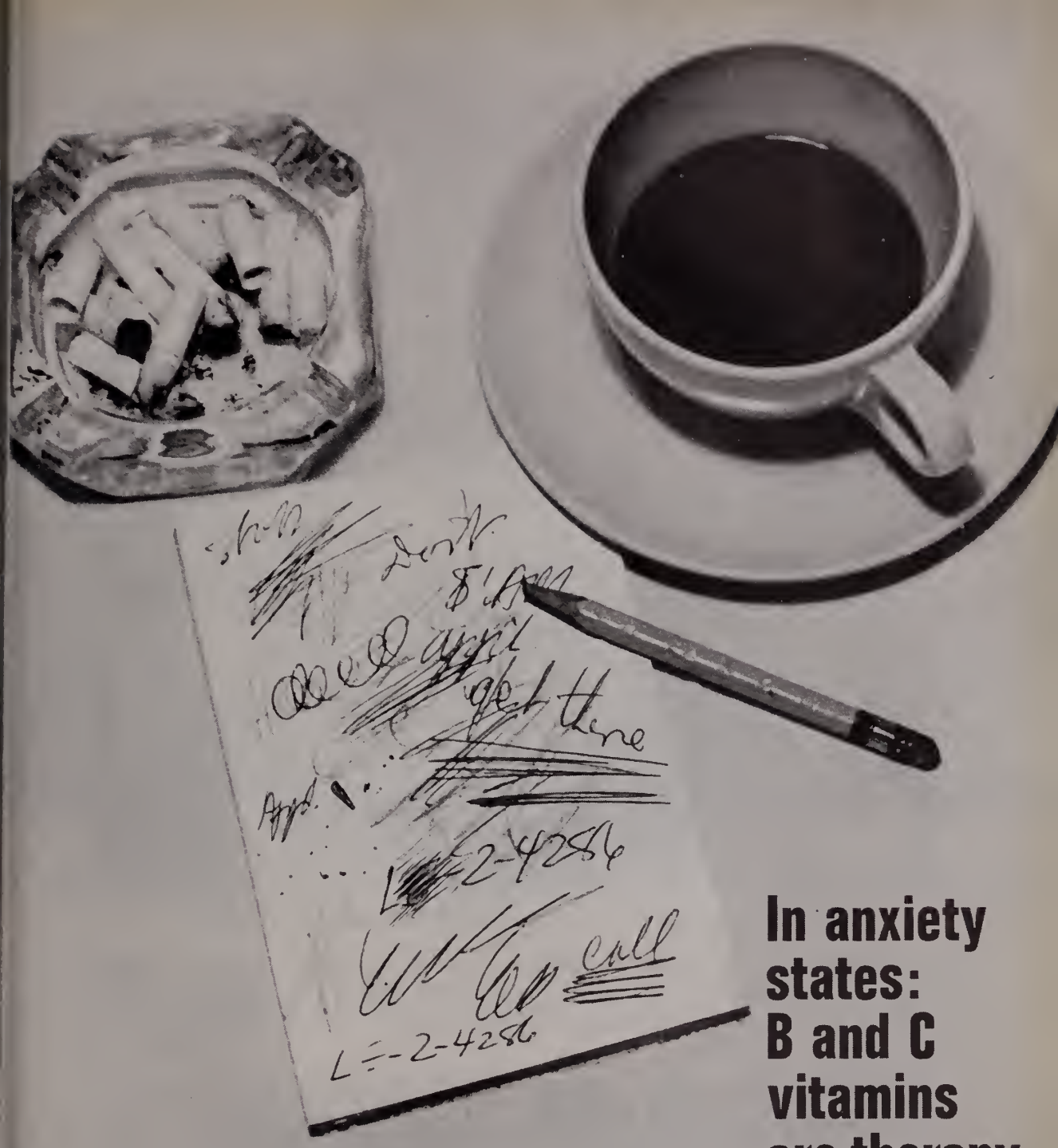
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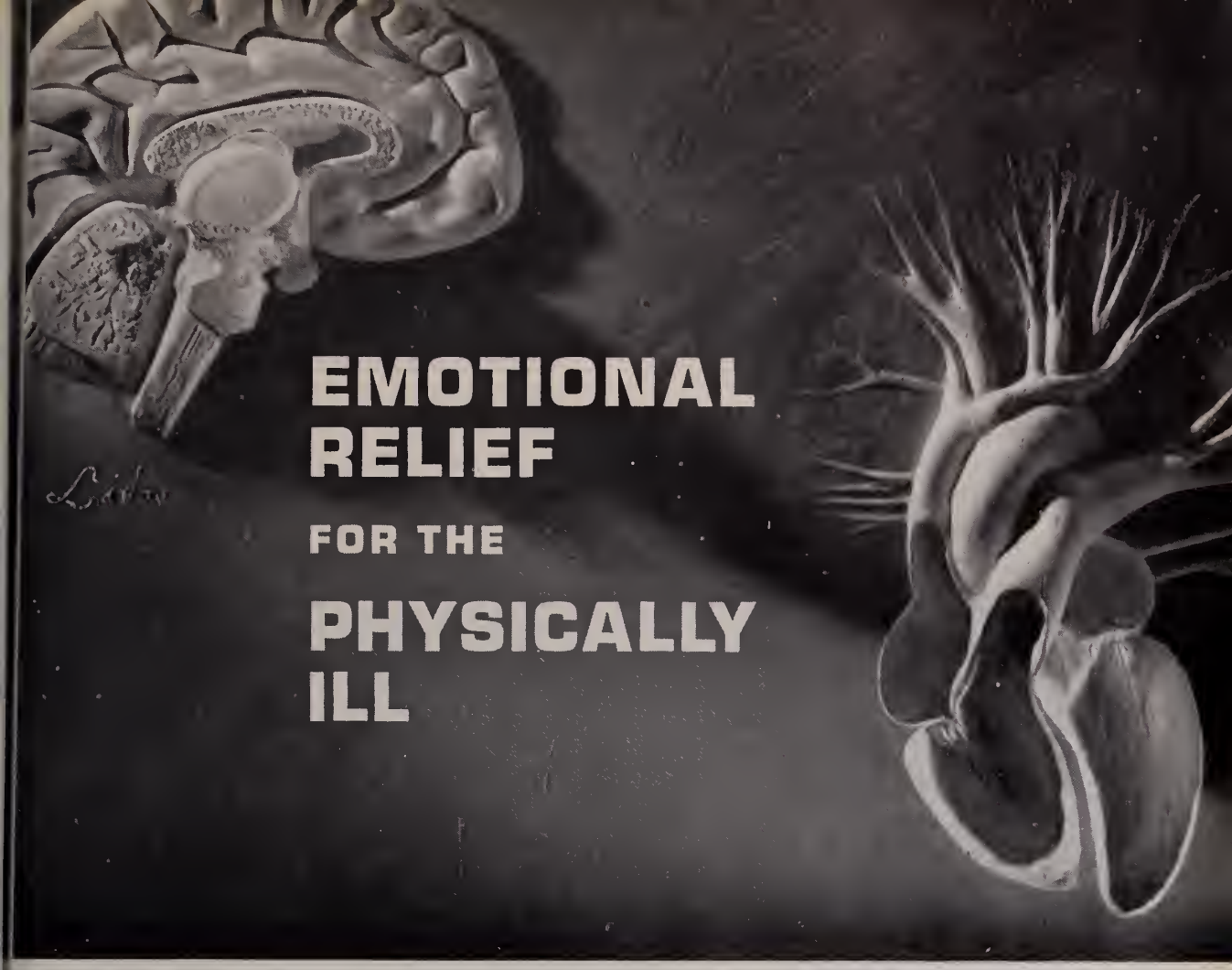
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EDITORIALS

Care of The Uninsured Indigent

Care of indigent patients is becoming a major problem in hospitals without intern and residency programs, a hospital director asserts in an article in the September 1963 issue of TRUSTEE (The Journal for Hospital Governing Boards).

Robert E. Toomey, director of the Greenville (S. C.) General Hospital, warns that if doctors don't allocate a portion of their time to teaching interns and residents and to caring for the indigent, hospitals may have to employ full-time clinicians for those patients. Mr. Toomey quotes Willard Rappelye, M.D. (formerly dean at the College of Physicians and Surgeons) who sees this practice of employing full-time clinicians as a new area similar to industrial medicine. He terms it "hospital medicine."

Hospitals face two other choices, Mr. Toomey suggests. The medical staff may set up a program to attract interns and residents; or the attending staff may organize to care for the indigent on a voluntary basis. These are different technics. "Full-time teachers," says Mr. Toomey, "are active allies in efforts to improve the quantity and quality of medical care throughout the hospital. Full-time clinicians appointed to care for the indigent are a substitute for voluntary efforts on the part of the medical staff." Another thing worrying Mr. Toomey is that as more Americans have become increasingly able to pay for their medical care and have received care from doctors of their own choosing, "physicians have had less time to devote to teaching and to voluntary medical care programs for the indigent."

Perhaps this is one reason hospitals having intern and residency programs seek full-time directors of medical education. They hope that through improved organization and management of the teaching staff and educational program, more doctors might want to participate in the hospital's teaching program.

In the past, care of the indigent has been handled either by staff members on a voluntary basis or by interns and residents under the direction of staff members. "In this way," concludes Mr. Toomey, "American medicine has grown and prospered. It has performed in a truly remarkable manner. However, new practices and procedures are continually developing. The whole tradition of hospital and medical care has been one of adapting to change."

Hospitals are coming to a moment of decision in this area, and it is hoped that their medical staffs will take the leadership in reaching that decision. Who is going to teach interns or residents? Shall it be private practitioners, doing this in their off-hours and without fees? Or shall it be salaried teachers or salaried clinicians? Who is going to render medical and surgical care to uninsured patients who can't afford fees? Shall it be interns, residents, salaried clinicians, or private practitioners —working without a fee?

We doctors cannot have it both ways. If we don't do the teaching and medical care ourselves, we can hardly object if another way is found for getting these services. The chance to make the decision is still in our hands. It may not always remain that way.

Information Overload

Everyone is worried about communication. How to get the message across is the current concern. With medical practitioners, though, there is danger of our being overloaded with information. There are hundreds of scientific medical journals now available, not to mention a half-dozen no-subscription magazines devoted to the administrative, economic, philosophical, and practical byways of medicine. Then we see detail men several times a week—occasionally even in pairs. And our mailmen develop kyphosis carrying tons of beautifully engraved

brochures packed with useful medical information. Information also pours in through graduate courses, closed circuit television programs, exhibits at medical conventions, regular medical society meetings, specialty association programs.

The danger now is that of information overload. With such a plethora of data competing for the doctor's time, thought, and energy, how does he sort out the myriad of impressions? We don't all react the same way to this relentless flow of data. Some hear what we want to hear, see what we want to see. Some become convinced anew with each item of information —with the result that the next patient gets the newest formula. And some of us just despair, and say: "Enough! Enough! I can't keep up with it all. I'll stick to tonics and sedatives."

Hospital Responsibility for Chronic Illness

The dramatic conquest of acute illness has emphasized the prevalence of chronic disease. People who once died of septicemia, pneumonia, childhood diseases, and peritonitis now survive and eventually may be disabled by arthritis, cerebral hemorrhage, mental illness, and cardiovascular disease. Neither physicians nor hospitals have been much enchanted by the chronic patient—who has been flippantly designated by contracting "chronic" to "crock." Yet a hospital *is* the logical place for treating chronic illness. Such patients, after all, need access to the same medical, nursing, and technologic staffs as the acutely ill, even though not at the same pace. And they need more of the facilities now available to short term illness.

In a recent study, supported by a USPHS grant and released September last by the American Hospital Association, the surveying team (Doctors Littauer, Steinberg, and Gee) made these observations:

The hours of nursing care required per patient per day in chronic illness categories were about the same as those of short-term patients. However, much less professional and much more nonprofessional nursing time is needed by the chronic disease patient. The long-term medical patient is better cared for in a chronic disease unit than when intermixed with short term patients. They find that:

"A chronic disease service tends to be more comprehensive and of higher quality when incorporated in the organic envelopment of the general hospital than when provided by an independent chronic disease institution."

However, such a service does not offer as valuable an educational experience for interns and residents as do short-term services, with greater turnover.

"Since house staffs are not assigned routinely, this creates a group of second-class patients with respect to coverage by doctors in an educational program."

The study discloses that a high proportion of patients in "acute" sections of the hospital are covered by hospital insurance but most patients in a chronic disease unit have none. They have been dropped from group arrangements, can no longer afford insurance, or have exhausted their previous coverage.

The report concludes that the weak financial position of these patients (who in more fortunate periods of their lives were self-supporting and able to pay hospital expenses) causes serious problems for the voluntary hospital. This has led them to the unpalatable conclusion that voluntary means of providing suitable health services for the chronic ill and aged will have to be bolstered by some kind of public support. As the average life span increases, as medicine makes progress, the pool of the chronically ill increases. The public will insist that they be taken care of. The medical profession is doing what it can, but the nub of the problem is in providing a bed and day-by-day nursing. If our voluntary hospitals refuse to take on this responsibility (ideally in chronic wings or pavillions of general hospitals) the Government will be getting pleas to step in. If a vast state or federal program burgeons in this field, we will know it was because a vacuum was left which some agency had to fill. He who runs may read.

We are all lamenting the increasing demand for hospital beds. Here is how one community, with initiative and imagination, moved a long way towards solving the problem.

Home Care Program of Camden County

Nathan Asbell, M.D./Camden

Home Care is not an innovation. Since the beginnings of recorded history, care at home has been an integral part of the practice of medicine. During the past decade, however, the concept has been enlarged to make it possible to bring to the patient's home many of the professional services of the hospital. And in recent years, the scope of home care programs has grown to include entire communities. The history of the Home Care Program of Camden County reflects this progress. In June 1962, a survey was completed of the patients in Camden County General Hospital with the hope of establishing a Home Care Program. In August 1692, the program was activated by the acceptance of two of these patients. In November 1962, it was extended to include all of Camden County. In the following month, three non-hospital patients were reviewed and accepted.

This project supplements available medical services in Camden County. The purpose is to bring to the patients of Camden County hospital facilities without hospitalization. It does this by providing, at the home of the patient, every medical facility necessary for rehabilitation that is obtainable in a hospital. By providing these hospital services at home, convalescence is shortened, rehabilitation enhanced, and optimum recovery assured.

There is no set standard for rehabilitation, other than that the best individual medical result be obtained, and that the patient be returned to society as a useful citizen. By getting these services at home, the patient is placed in an environment most conducive to his rehabilitation. Home environment provides a psychological and inspirational stimulus both to the patient and family alike. This is rarely obtained in a hospital atmosphere. The patient is in a friendly, familiar environment, and the family can participate in the treatment. They are instructed and encouraged to play an active role in the medical regime. This rapport facilitates the patient's recovery.

To achieve these results, it became apparent that many facilities were needed and that these must be controlled at a central headquarters. Camden County General Hospital, for many years, has devoted itself to the care of the chronically ill. Its medical and administrative policies are adapted for patients in this category. Rehabilitation plays a major role in the services provided by Camden County General Hospital. This and every other department has been made mobile, so that it can render service to patients inside and outside the hospital. In effect, it has become a "hospital on wheels."

The scope of this program was made as comprehensive as possible in order that a full range of medical and allied services be made available. These services include: general and consultative medical facilities; visiting nursing care;

physiotherapy; occupational therapy; social service; nutritionist; homemaker; and laboratory facilities.

The medical services are provided by a staff doctor or by the family physician. If a specialist is required, arrangements are made to provide one. The Rehabilitation Department of the hospital provides all modalities for the many aspects of this field. Appliances and prosthcses also are available. Community services are used to the fullest extent, including the assistance of the Visiting Nurses Association, the Homemaker Service, and the County Nutritionist.

A conference is held at fortnightly intervals. At these conferences, representing the component parts of the program, are the following personnel: medical coordinator; administrative coordinator; physicians; physiatrists; social workers; nurses (both general and rehabilitative); physiotherapists; nutritionist; the patient; and the family and any other personnel who play a contributory role in the rehabilitation of the patient.

While the title of the project is "Home Care," we interpret the word "home" very broadly. We think of "home" as the domicile most conducive to the patient's recovery. Often, of course, this does mean the patient's home. But if that is not conducive to recovery, we can arrange for the patient's placement in convalescent facilities, nursing homes, boarding homes, or, indeed in any other suitable facility.

At the conference, each patient is thoroughly evaluated, and acceptance or rejection is determined. Age or disease does not influence acceptance; however, the patient must be suited to the project and the program must be seen as beneficial to the patient. Once the patient is accepted, a complete regimen is established. The medical necessities are determined and the departments of the program necessary to provide these are assigned to the case. Patients are accepted from other hospitals, as well as from any private physician. The procedure, therefore, is bi-phasic regarding medical supervision. In all cases, the family physician is encouraged to provide the medical services. He is fully informed of the regimen that has been established and of his responsibility both to the patient and to the program. If he does not accept the patient, medical services are then provided by the staff of the program. Each case is routinely reviewed at six-week intervals unless circumstances dictate earlier re-evaluation. There have been patients who have required re-admission to the hospital or change in their medical or environmental regime. These are treated on an emergency basis.

The cost is met through various media. Patients are admitted to the program on the basis of need for medical services and not on financial status. Each patient is asked to assume financial responsibility to whatever extent he is able. Hospital personnel, medical and administrative, are utilized to the fullest extent. The County Welfare Board contributes to patients enrolled with them. A grant from the State of New Jersey initiated (and now partly subsidizes) the program.

Here are our first year's figures:

Municipalities in Camden County	37
Team conferences held	26
Patients considered at conferences	72
Patients admitted to Home Care Program	51
Total patients days	5925
Patients discharged from the program	28
Cash received (nearest dollar)	$15,061
*Savings to hospital	$79,987

Summary

A Home Care Program will go far towards meeting the mounting needs of an increasingly "old-age" population and a decreasing availability of hospital beds. The program here described is suitable for any community.

* This is computed on an in-patient *per diem* of $13.50, and this figure is multiplied by the 5925 figure.

326 Cooper Street

Dr. Baldwin here offers a simple, schematic way of determining whether bleeding is due to clotting factor deficiency—and which one.

The Diagnosis of Clotting Factor Deficiencies

Richard D. Baldwin, M.D./Skillman

Excessive blood loss into an unusual site or without clear-cut cause should be investigated. Troublesome nose bleeds, easy bruising, heavy and prolonged menstrual flow are clues which should initiate an investigation of the patient's hemostatic capacities.

The doctor would here be concerned with capillary integrity, the number and adequacy of platelets, the existence of "anticoagulants" and fibrinolytic agents, and the adequacy of blood clotting factors. The last is one on which there is considerable confusion. I will try below to provide a firm orientation which will make meaningful and profitable the study of standard works like Wintrobe's *Clinical Hematology*[1].

The coagulation mechanism (as it is presently thought of) is easily grasped and provides a good framework upon which to base a rational workup. It consists of four phases: *Phase I:* reactions leading to the formation of thromboplastin; *Phase II:* the production of thrombin; *Phase III:* the formation of fibrin; and *Phase IV:* clot lysis.

Phase I

Eight substances, seven of which are thought to be distinct plasma proteins, are presently implicated. These are factors V, VIII, IX, X, XI, XIII, platelet factor 3, and factor IV (calcium). If one of these is present in deficient amounts or in an abnormal form the production of thromboplastin is impaired. Calcium (factor IV) is so rarely at fault that it will not be considered; such small amounts are needed that they are always present, even in severe hypocalcemia.

Factors V and X also are involved in phase II.

Phase II

Prothrombin exists in the plasma as a protein molecule with a weight of about 62,700, containing 18 amino acids. Under the influence of thromboplastin and with the aid of factors V, VII and X, it is broken down into a molecule of Thrombin.

Phase III

Thrombin produced in Phase II acts on fibrinogen and converts it to fibrin. Fibrinogen is a large protein molecule produced in the liver. Thrombin is a proteolytic enzyme. It splits fibrinogen into a molecule of fibrin and two soluble peptide molecules. The fibrin molecules then polymerize into multimolecular strands which form the fibrin mesh.

Phase IV

Clots do not persist *in vivo*. After some time the fibrin is lysed and resorbed. This involves a fibrinolytic mechanism which may contribute to hemorrhage in liver disease, hematological malignancies and acute infections.

[1]Wintrobe, M. M.: *Clinical Hematology*. Lea & Febiger, 1961, Philadelphia, Pa. Ed. 5

Synonyms for some of the clotting factors are:

Factor I — Fibrinogen
Factor II — Prothrombin
Factor III — Thromboplastin
Factor VIII — Antihemophiliac globulin
Factor IX — Christmas factor. PTC (plasma thromboplastin component)
Factor XI — PTA (plasma thromboplastin antecedent)

Clotting Defects

Defects in the clotting mechanism occur if one or more of the clotting factors is abnormal in quantity or quality. Abnormal hemostasis (*in vivo* cessation of bleeding) and abnormal coagulation (*in vitro* clotting) may be due to other causes such as abnormal capillary retraction or platelet agglutination or to substances which block specific clotting factors (anticoagulants). The task of the physician is to pinpoint the fault. A procedure for doing this is described.

Evaluating Blood Loss

Evaluation of abnormal blood loss consists in answering four questions: (1) Does a hemostatic defect exist? (2) Are the capillaries or platelets at fault? (3) Is there a fault in one of the phases of coagulation? If so which one? (4) If phase I, II or III is abnormal, which factors are involved? All four of these questions are answerable. Tests designed for this purpose are simple and available; the remainder of this article deals with these.

The history is of great value. If a hemostatic difficulty exists there will generally be a suggestive history. Diligent questioning about items the patient may overlook (such as nosebleeds, bruising, and heavy "periods") may establish the defect with some certainty in the physician's mind. A family history of bleeding difficulties adds to this possibility.

On the initial office visit, seven simple tests are done. These are: (1) stool guiac for occult blood; (2) a microscopic examination of the urine for red blood cells; (3) a tourniquet test; (4) bleeding time; (5) coagulation time; (6) a qualitative clot retraction evaluation; and (7) examination for clot lysis.

After the stool and urine samples are obtained, a blood pressure determination is made on one arm. The cuff is left in place and reinflated to a pressure midway between the systolic and diastolic pressures and maintained at this point for five minutes. At the end of this time the minute flea-bite hemorrhages are counted in a 4 centimeter circle (cut out of a filing card) at a point 4 centimeters below the elbow on the flexor surface, midway between the elbow and wrist on the extensor surface of the forearm and on the dorsum of the hand. These values are added. A count of more than 20 is abnormal. The test should not be repeated on the same arm for one week.

The cuff is then transferred to the other arm and inflated to 40 millimeters. Two punctures 5 millimeters deep are made 2 centimeters apart on the flexor surface of the forearm. Be careful not to disturb the clot forming over the wound. The still liquid blood is then soaked away from the edges with a piece of tissue. Normal bleeding time by this method is 1 to 9 minutes.

The cuff is removed. Four milliliters of blood are withdrawn by venipuncture using an 18 gauge needle and a glass syringe previously treated with Clay Adams Siliclad® solution. Two milliliters of blood are gently expressed into each of two new 13 x 100 millimeter Pyrex® tubes. A stopwatch is started when blood is introduced into the first tube. After both tubes have remained at room temperature for 5 minutes, the first tube is tilted every 30 seconds until it can be turned completely upsidedown without spilling. The second tube is then treated likewise. The period until complete clotting of the second tube is the coagulation time. Using this procedure, the normal clotting time is 6 to 17 minutes.

After both tubes are clotted, they are plugged with cotton and inserted in a water bath or in a beaker of water placed in an incubator, and kept at 37 centigrade degrees. They are observed at 30 minutes and at 2 hour, 24 hour, 48 hour and 72 hour intervals. The clot normally begins to retract in 30 minutes to 1 hour after it was drawn. This is delayed if the platelets are low in number (thrombocytopenia) or abnormal in character (thrombocytopathia). The tubes are examined daily for 72 hours. If the clot lyses within that time, the tube contents are poured through gauze. Only if no clot particles remain is clot lysis said to be complete.

	Normal Serum	Adsorbed Plasma
Factors Present	VII, IX, X, XI, XII	IV, V, VI, VIII, XI, XII
Factors Absent	I, II, III, V, VI, VIII	I, II, III, VII, IX, X

Complete lysis does not normally occur within 72 hours. If lysis does occur the presence of abnormal fibrinolytic agents is presumed.

A Quick one-stage prothrombin time, a prothrombin consumption test, and a platelet count are then ordered at a reliable laboratory.

Evaluation

At this point the physician has important information. If the blood clotted at all, fibrinogen is present for fibrin has formed. If clot lysis has not occured, Phase IV is normal. If the prothrombin time is prolonged, Phase II is defective. If the prothrombin consumption test is abnormal, something is amiss in Phase I.

Next, consider the *prothrombin consumption test* and the *thromboplastin generation test.* Factors VII, IX, X, XI, and XII are present in normal serum (the liquid portion of the blood remaining after clotting has taken place); factors I, II, III, V, and VI are not. If 0.2 milliliters of aluminum hydroxide gel (Amphogel®, Wyeth, unflavored) is added to a milliliter of plasma (liquid portion of blood remaining after centrifugation of unclotted blood) and the mixture centrifuged, certain clotting factors are adsorbed on to the aluminum hydroxide and removed. Factors I, II, III, VII, IX, and X are removed in this way. Review the table at the top of the page.

If a normal amount of thromboplastin (factor III) is formed in a blood sample, it will convert all (or almost all) of the prothrombin present to thrombin. Thus, one would not expect to find much prothrombin in the serum from a person with all factors intact. However, if Phase I is defective and abnormally small amounts of factor III are formed, then excessive amounts of prothrombin (factor II) will remain unconverted to thrombin when the blood clots. Consequently the serum from a patient with a Phase I abnormality will contain greater than normal amounts of factor II. This unconverted factor II is assayed by the prothrombin consumption test.

Prothrombin Consumption Test

A sample of the patient's blood is allowed to clot. It is then placed in a water bath at 37 centigrade for two hours. This inactivates the heat labile thrombin and any Phase I factors which may be there. Any factor II present is unaltered. Some of this serum is mixed with commercial thromboplastin to convert the Factor II to thrombin. The clotting effect of this mixture on a solution containing fibrinogen is determined. The time required for the clot to form varies inversely with the concentration of factor II. If the test serum clots faster than a normal control it contains more factor II than normal. If an increased amount of factor II is present, less than normal amounts must have been converted to thrombin. This in turn indicates an abnormality in thromboplastin (factor III) formation (otherwise the conversion of factor II to thrombin would have been more complete). Attention is thus directed to Phase I and the specific abnormality therein must be indentified. This is accomplished with the ingenious thromboplastin generation test.

Thromboplastin Generation Test

Eight factors are necessary for the formation of factor III. These are factors IV (calcium), V, VIII, IX, X, XI, XII, and platelet factor 3. Six preparations are prepared. These are: (1) A suspension of normal platelet; (2) A suspension of patient's platelets; (3) adsorbed normal plasma; (4) absorbed patient plasma (5) normal serum and (6) patient serum.

A preliminary run is made to affirm that a Phase I abnormality is present. This is done as follows. Normal serum, normal adsorbed plasma, normal platelets, and calcium are mixed. No clot forms since factor I is absent. At 3, 5, 7, and 9 minutes 0.1 milliliter of the mixture (in which factor III has formed) is mixed with 0.1 milliliter of normal citrated plasma (a source of Factor I and Factor II). The time taken for a clot to form in each instance is carefully measured. The same procedure is repeated using patient serum, adsorbed patient plasma, patient Platelets, and calcium. At 3, 5, 7, and 9 minutes some of this mixture (which may or may not have formed factor III in less than normal amounts) is mixed with citrated plasma. The time for clotting in these mixtures is also carefully measured. The shortest time for a clot to form in the tubes prepared from normal materials is compared with the shortest time obtained with the patients components. If that of the patient system is 5 seconds or more in excess of the normal mixture, a Phase I clotting defect is likely and the remainder of the test is run.

Four tubes are then set up as follows:

Tube No. 1: (a) Normal serum; (b) adsorbed plasma from patient; (c) normal platelets.
Tube No. 2: (a) Normal serum; (b) adsored, known-normal plasma; (c) test platelets;
Tube No. 3: (a) The patient's serum; (b) adsorbed, known-normal plasma; (c) normal platelets;
Tube No. 4: (a) Patient's serum; (b) adsorbed plasma from patient; (c) normal platelets.

For normal clot formation, this system depends on the following factors being *contributed by the patient:*

Tube 1: V and VIII
Tube 2: Platelet factor 3
Tube 3: IX and X
Tube 4: All but platelet factor 3.

If the clotting time of tubes 1, 2 or 3 are prolonged, the responsible factor is identified as follows: Factor V is differentiated from factor VIII, and factor IX from factor X by the prothrombin time. Deficiencies of factors V and X prolong the prothrombin time, while factor VIII and IX deficiencies do not. If tube 2 is abnormal, a platelet count differentiates between thrombocytopenia and thrombocytopathia.

If the preliminary run on the thromboplastin generation test fails to demonstrate a Phase I defect and the prothrombin time is prolonged, either factor II or VII is at fault. A two-stage prothrombin test will determine whether or not factor II is deficient. If not, factor VII is left by exclusion.

Once the specific factors have been presumptively identified, simple tests are available to confirm the inference and to quantitate the deficiency. These are simple in principle. For example, a known factor VII deficient blood is mixed with a suspected factor VII deficient serum. The extent to which it corrects, or fails to correct, the clotting defect as compared to a normal control serum used likewise gives an estimate of its concentration.

The physician now knows whether his patient is bleeding because of a clotting factor deficiency and, further, which one is at fault. Reference to any standard textbook will supply a full discussion of the clinical picture of each deficiency disease and indicate the proper therapy.

1 Montgomery Road

Courses Available in Philadelphia

The Einstein Medical Center announces the availability of special graduate courses for physicians and dentists. Conducted by Medical Center specialists, the courses range from 15 three-hour classes on "Basic Electrocardiography" to a one-day session on "What's New in Dentistry for the General Practitioner?" Tuition fees vary from $25 to $85. Clinical material will be available for teaching, augmented by audio-visual aids. Enrollment is limited to allow individual instruction. Diagnostic and therapeutic innovations will be translated into their every day practical applications. Credit allotted by the American Academy of General Practice and the Academy of General Dentistry will be given its members. Others may request a certificate of attendance.

Courses offered in the fall of 1964 are: gastroenterology; electrocardiography; what's new in dentistry for the general practitioner; dermatology; diseases of the vascular system; office surgery; mammography; kidney disease; and clinical endocrinology.

Courses offered in the spring of 1965 are: psychiatry and general practice; advanced electrocardiography; the periodontal patient; clinical allergy; and a symposium on rheumatic and congenital heart diseases.

The Medical Center is a constituent of the Federation of Jewish Agencies of Greater Philadelphia and of the United Fund.

For more details, write to Dr. P. F. Luchesi, Einstein Medical Center, York Road at Tabor, Philadelphia 41, Penna.

The doctor's influence may be felt between visits, if the therapist will write—and give the patient—a handbook or manual about his condition.

A Patient's Handbook As an Aid in Psychotherapy

Harry Hoffman, M.D./Plainfield

Psychotherapy is an insight-gaining, instructive, attitude-changing process, akin to education in its broadest sense. It puts the doctor into the role of an educator, or teacher. If we think in terms of a teacher-pupil relationship, then we may see sense in using fundamental teaching procedures, one of which could be "a textbook for the course."

There is always a need to shorten the unconscionably long time necessary in much of individual psychotherapy. Group psychotherapy and electronic aids like tape recorders have saved time and enriched psychotherapy through their own special characteristics.

Designated reading by patients is an uncommon prescription. It does not seem especially desired by psychotherapists. And, indeed, at the start of treatment, accessory aids would be only confusing. One hardly gives a first grade student a textbook or collateral reading to interfere with the first flow of information from the teacher! Furthermore, the diversities of theories, technics, and philosophies would preclude the easy adoption of uniformly acceptable material. We are far away from having a Spock in our field!

A Special Manual

This paper reports experience with a typed manual, written by myself, with our "average" patient in mind as reader, student, and patient. It covers popular psychologic mechanisms, with emphasis on cause of difficulty as due to what we may more technically state as "constitutional feelings of inadequacy" and "low ego strength."

With its emphasis on low ego strength, inferiority feeling, and heredity, it is obvious that this manual expresses the highly individualized and personalized viewpoint of this particular therapist. Psychotherapy being what it is today, such manuals would have to be highly individualized. Advantages and disadvantages both result from this. The personalized manual fosters closer rapport and better dependency relationships in the beginning. Disadvantages are that there is less "scientific" uniformity of viewpoint, with poorer transfer from one therapist to another, and even suspicion because of divergencies of theories. Furthermore, each therapist has to go to the trouble of authoring his own teaching aid. Handled properly, the manual will be seen by the patient as an extension of the therapist. Thus, the therapist's effects would be present between sessions, during his absence, and after the regular course of therapy was over.

With some patients, visual comprehension is quicker and more deeply implanted than auditory. And a greater amount of material from the therapist is available to the patient if the manual is fairly ample in size. One of my patients said: "I never really doubted anything you said, but I didn't completely believe it until I saw you had it all written down!"

The last page of the manual is a summary. It may be informative to give it here, verbatim:

I have tried to point out in this discussion that there is one common factor that explains most of our "nervous" pain. This factor is due to the way in which a part of our brain works. The make-up of this part of our brain and the way it works is determined by inheritance. What it does to us, or the way in which it makes us act, is in giving us "feelings of not being good enough" or "feelings of needing to do more" or "inadequacy feelings." These feelings color and determine all our life experiences and color all our other basic personality traits. The degree of this "feeling of not being good enough" determines the degree of painfulness of our other painful traits, such as fear and depression. And this "feeling of not being good enough", because it threads its way through our lives and interweaves itself with other personality traits, I call *The Common Thread.*

What I have hoped to accomplish is relief from pain. I have tried to demonstrate the workings of this common thread to those who have it in a painful degree, so that through clearer knowledge they might easily avoid some of the pain of this common thread and more contentedly accept the rest.

The manual was given to 125 patients. As the supply of copies was originally limited, the average amount of time a patient had the manual in his possession was about six weeks. With more copies now available, the manual will be owned by the patient.

There was definite selection of patients. The manual was intended only for those with "anxiety states" and mild to moderate depressions. As might be easily guessed, the diagnosis would often be changed after the manual was issued and other types of patients would end up having used it. This was not especially unwanted; the schizoid and character disorder patients were not so ill as to be adversely affected. They may even have derived some benefit.

The timing of the giving of the manual is important. Confusion sometimes resulted when the manual was given after the first interview. A lengthy initial interview, one and a half hours or longer, plus the reading of 100 pages, may prove too much to swallow at one time. Generally, if things went along fairly well, the exhibition of the manual after the third or fourth interview seemed appropriate.

The diagnostic categories of the 125 patients were as follows:

Psychoneurosis, anxiety state	60
Psychoneurosis, obsessive-compulsive	3
Combined anxiety, depressive, and schizoid traits	26
Character Disorder	8
Manic-depressive state	9
Reactive depression	16
Paranoid state	3
	125

Genetic mechanisms (not as widely emphasized in the popular magazines as in our professional publications) make for much reflection among patients and are therefore productive. There seems to be a crude shock value in their seeing a major switch from their previous "environment" thinking. Statistical results are not feasible in this study. It is my opinion, however, that appreciable time and expense are saved for the patients and that deeper and broader insights are developed.

Summary

Psychotherapy has many specific teacher-pupil relationships. Therefore "a textbook for the course" may be appropriate. A 100-page typed manual written by the author was given to 125 patients, mostly with anxiety and depression, as a psychotherapeutic adjuvant. Such a manual, offered to the patient, should be written by the patient's own therapist and seen by the patient as a personality extension of his physician. I feel that time and money were saved and that more productive stimuli were applied to patients.

835 Third Place

Emergency Diagnosis of Syphilis

It is imperative that the health authorities immediately interview patients on whom you have made a diagnosis of primary or secondary syphilis. To help, the State Health Department will render immediate darkfield examination for any physician who has a patient in his office. To get this swift service, proceed as follows: if you are in area code 201, yourself, dial: 609-392-2020. If you are in south Jersey (area code 609 zone), simply dial EXport 2-2020.

The relief of pain is probably the commonest symptom which sends the patient to the doctor.

Pain VI: Its Management*

Fred A. Mettler, M.D.
New York

Any decision about management of pain assumes that the case has been thoroughly evaluated and that reasonable estimates have been reached as to (1) the anticipated course of the condition causing the pain, (2) the life expectancy, and (3) responsibility, of the patient. Obviously, from what has been said in the last of this series of papers[1], tractotomy ought *not* to be tried in a patient with a life expectancy much beyond three months if there is any other way of coping with the problem of pain. Lobotomy ought to be avoided in an individual whose mental competency might subsequently be legally challenged. Two of the four therapeutic approaches to pain are available to the general practitioner (psychotherapeutic and pharmacologic). The remaining two approaches are surgical—general surgical (peripheral nerve blocks and section) and neurosurgical (root section, tractotomy, sympathectomy, and lobotomy).

If it is true that the least amount of drug which will achieve the desired result is the correct dose it is even truer that no dose is best of all if acceptable results can be achieved without drugs. Enough has been said in previous communications to suggest that there is a considerable area in which the general practitioner who will take the time can maneuver with some degree of success in treating patients with pain by using a variety of methods of reassurance, exhortation, and attention to general hygienic procedures. Three special additional procedures are worthy of particular comment. The first of these involves attention to the application of the principles of physical medicine. It is doubtful whether any treatment technic will be satisfactory in the ambulatory patient, with good life expectancy, if a definite and rather rigid regimen is not followed. The use of inexpensive exercise and adjuncts, such as heat and baths, is only a matter of good sense. In the second place attention should be given to relaxation. It makes little difference whether one chooses a formalized routine, such as that which has become known under names such as "progressive relaxation" or "active relaxation," or whether one can achieve similar results by less obsessive means. The point is that the regimen should give particular attention to the specific matter of patient cooperation, with the aims of reducing muscle tension and emptying the mind of concern, insofar as this is possible.

The third specific procedure to be considered is hypnosis. This has its particular application in patients with good life expectancy whose pain is caused by a chronic organic condition. Such cases, in the hands of a person who has the time to devote to hypnosis and a personality suitable for it, can achieve definite benefit, but the demands made upon the time of the physician are often beyond the means of most patients.

The general practitioner's requirements of the materia medica for pain are somewhat specialized. He is often as much interested in the sedative effect of drugs like codeine, morphine or meperidine hydrochloride as he is in their analgesic properties. He cares relatively less about the respiratory depressant effects of such drugs than does the surgeon. On the other hand, he must be constantly concerned with

* From the Department of Neurology and Anatomy at Columbia University, this paper is based on a talk given by Dr. Mettler to the Department of Anesthesiology there on May 21, 1963.

[1]Mettler, Fred A. Journal of The Medical Society of New Jersey, 61:10, 62, 113, 181, 231 (1964)

the problem of addiction (which, with the possible exception of d-propoxyphene hydrochloride and pentazocine, seems to be as pronounced with the effective newer synthetics as with the old drugs) and constipation (which is less with d-propoxyphene and piminodine than with codeine). One newer drug—dextromonoramide—seems to have no compelling advantage over morphine; another (piminodine) tends to produce hypotension (which may be advantageous or disadvantageous); and another, pentazocine, remains to be more completely investigated—especially with regard to nausea and ataxia. Methadone hydrochloride produces nausea more easily than d-propoxyphene, and is cumulative. The non-addictive features of some of the newer drugs evidently depend upon their unpleasant side effects.

There are good reasons for barbiturate combinations in conditions such as headache (Fiorinal®) or muscle pain (Daprisal®), where effects other than simple analgesia are desired. Every physician will have his favorite proprietary combination in this rapidly proliferating field. Combinations may be more desirable for protracted use than are the specific analgesics. There is also something to be said in favor of the use of ethanol.

The general practitioner who tries nerve block is inviting difficulty. It is necessary to come to a decision as to when patients should be referred for general surgical procedures. Although nerve blocks are widely employed for causalgia, that condition, if intractable, should be treated by sympathectomy. Infiltration of "trigger points" in complaints of muscular and joint pain (though not nerve blocks in the proper sense of the word) may also be considered here. With a chronic process, there is little to be gained in the long run by such infiltrations. Long-term relief is often observed in musculoskeletal disorders, but it is to be doubted whether the infiltration deserves credit for this. With the exception of trigeminal neuralgia, nerve blocks seem to have their principle applicability in acute traumatic situations where specific nerves can be clearly identified as playing a significant role. Opinion is divided among neurosurgeons about the propriety of blocking technics for trigeminal neuralgia. There can be little doubt, however, of the completely satisfactory nature of this procedure in elderly emaciated patients who could not sustain more radical procedures. Such people may have dramatic relief, put on weight, and live for many productive years thereafter. The secret of success lies in the skill of the neurosurgeon, and the procedure should never be attempted by anyone but a neurosurgeon. Sympathetic blocks have been recommended for a wide range of procedures including the pain of vascular spasm, causalgia, and the early, acute phases of herpes (to prevent the fixation of the engram of pain; it does not relieve post-herpetic neuralgia). Sympathetic blocks are particularly valuable for predicting the results of anticipated surgery, especially in post-traumatic pain of the hands or feet, or post-traumatic arthritis, in which the pain is increased by vasomotor activity.

Neurosurgical manipulative procedures involve intrathecal injection of alcohol or, more recently, phenol about the dorsal spinal roots. Phenol, formerly thought to affect the small fibers only, is now known to attack fibers of all calibers. Motor complications are less frequent with this chemical than with alcohol. Analgesia is more pronounced than is hypesthesia. The procedure is useful for painful involvement of the lumbosacral outflow. Posterior rhizotomy does not eventuate in the postoperative paresthetic complications of tractotomy but a wide denervation must be utilized to relieve pain effectively in any given area.

Since anesthesia rather than simple diminution of pain follows this procedure, it is not suitable in the region of the extremities if the pain is widely distributed. Once post-herpetic neuralgia becomes established, sympathetic blocks are without effect. Neither rhizotomy nor tractotomy afford wholly satisfactory relief, though tractotomy is considered to be somewhat helpful. A procedure offering some possibility of success is peripheral denervation by undercutting (or excising) the sensitive dermatome. Sympathectomy is the operation of choice for causalgia. The reason for this has been previously explained. It is also, for obvious reasons, the optimal procedure for intractable pain of visceral origin, or pain in which vas-

cular constriction (cold moist extremities) is a factor. Frontal lobotomy or leucotomy provides effective relief for the distress of intractable pain in cases in which life expectancy is very limited.

No pain case should be allowed to leave the office without a specific follow-up appointment. If there is any doubt about the cause of the pain the condition should be handled on the basis of a tentative diagnosis. The most useful diagnostic aid is, as always, repeated examination. If the patient is given a prescription and not told to return, he or she may "shop around" when the medication runs out. If upon repeated re-examination the condition remains obscure, it is time to call a neurologist into consultation. If, with the evolution of the disorder, an easily identifiable and accessible pathologic state becomes evident, the patient may resent the fact that he was not required to return, and may even institute a lawsuit for neglect. Habit-forming substances should be so designated; and potentially toxic materials, like phenylbutazone, should not be dispensed without explaining their side-effects and hazards, and making an *advance* appointment for a laboratory check-up. The complications and hazards of proposed surgical procedures should be explained ahead of time. The patient should then be left to himself to come to an acceptance or rejection of surgery.

One often sees patients who have long histories of pain; who have had extensive, diverse surgery; who are taking three or more type of drugs (analgesics, sedatives, and tranquilizers) at the same time (and often several brands of each); who are haggard, emaciated, anorexic and constipated, and display a parkinsonian picture. Such persons may present a mixture of complaints emanating not only from their original condition but also from postoperative complications and medication. Such emotional and intellectual reserves as the patient may still possess are not infrequently counteracted by drugs which impair adaptive capacity. There is often occasion to reduce and eliminate, rather than to increase or substitute, medication; and dramatic improvement is often observed in patients who can be kept off medication for as long as two weeks. If no other method seems likely to succeed, the patient may have to be hospitalized in a properly monitored psychiatric ward to control access to drugs. In no case receiving extensive medication should a final evaluation of the patient's true condition with regard to pain be made until one is satisfied that the medication is not complicating the clinical picture.

630 West 168th Street

Fellowship In Medical Science

The Glorney-Raisbeck Fellowship in the Medical Sciences for the next year will be awarded by The New York Academy of Medicine for research and/or study in any field of medicine or allied sciences. The Fellowship may be renewable on a year-to-year basis for two additional years. The stipend is $7,500. It is open to holders of the M.D. degree who have demonstrated potential for productivity in research and teaching, and who are near enough to New York to make themselves available for interview by the Committee.

A candidate should be prepared to give assurance that he will have an institutional appointment which will enable him to carry out the objectives of his program of research and/or study. Such institutions will be encouraged to supplement the Fellowship stipend.

Deadline for receipt of applications is November 1, 1964. Requests for application forms should be addressed to:

Aims C. McGuinness, M.D.
Committee on Medical Education
The New York Academy of Medicine
2 East 103 Street
New York 29, New York

The views expressed in this vigorous polemic are, of course, those of the author. The Society has not taken a position which would accord with Dr. Miller's conclusion.

The Narcotic Problem

A Challenge to Physicians

Howard B. Miller, M.D./Fairlawn

Narcotic addicts are sick people and need physician's care. It is now time for all of us to face this fact and ask that this responsibility be returned to the medical profession. Police control of the addict is, I suggest, unwarranted. Policemen are fine law enforcers, but they are not physicians. Why should the problem of addiction be entrusted to them? Certainly they should control the traffic in narcotics as far as the supply and sale of it are concerned: but they are not qualified to determine our attitudes and treatment of the addict himself.

This peculiar situation is not new in history. A short time ago, the insane were policed, chained, and beaten before courageous men smashed the prejudice which existed. Freed from the threat of police action, physicians were then able to cope with the problem. The development and growth of psychiatry resulted, to benefit all mankind. Today, the distortion in interpretation of existing laws keeps the narcotic problem in a similar position.

The United States today has the greatest problem of narcotic addiction of any Western country. Social and medical studies show our approach to the problem is deficient in all respects. Ninety percent of patients become readdicted within 6 months of treatment in federal institutions. No local community responsibility and care exist on any adequately functioning level.

The Harrison Act of 1914 was intended as a revenue measure, prescribing taxes and licenses. It properly stated that narcotics could be prescribed for medical purposes. The law was enforced by the Revenue Department until 1930, when a separate Bureau of Narcotics was established. The Harrison Act was never intended to keep the ill addict from physicians' care. Only distortion and misinformation resulted in this monstrous development*.

To emphasize this distortion, I here cite three recent interviews.

1. In a recent interview, S. Bernard Wortis, M.D., dean of the New York University School of Medicine, noted that narcotic addiction is the only disease with its accompanying physiological and mental disturbances that the physician is forbidden to treat under penalty of law.

2. I have had personal correspondence with many physicians who stated that they "would not treat addicts because they were told not to do so". This is why they "report the addict to the police officers." They emphasized that all physicians knew the addict was a sick person, but were afraid to treat him.

3. In a recent interview (February 1963) Dr. James V. Lowry, Assistant Surgeon General of the U.S. Public Health Service, spoke at the first Inter-American Conference on Legal Medicine and Forensic Science, held in Puerto Rico, and is summarized as follows:

"In the United States, jails are open to addicts, but hospitals are commonly not." He compared the present availability of hospital treatment for addiction "with that for mental illness a century ago."

"Many addicts", Dr. Lowry said, "are too ill to overcome the compulsion of addiction and seek treatment. But if facilities were available such addicts could be involuntarily hospitalized." He warned, however, that unless hospitals are available for actual treatment, civil commitment laws are "useless legal instruments." They are, he said, "devices for imprisonment under another name." He added: "Neither medicine nor law should make hospitalization for the treatment of drug addiction a dogma unchecked by controlled research on other methods of treatment." Emphasizing that it is a mistake to overestimate the significance of relapse, he said, "Relapses, even to the point of readdiction, call for treatment directed to the cause and prevention of further relapses. Relapse does not mean once an addict, always an addict, there are recoveries even after numerous relapses. Whether it becomes readdiction or only a temporary setback may depend entirely upon how it is treated." Dr. Lowry also said that while legislative bodies have been enacting tougher laws against sellers of narcotics, humane prosecutors often accept lesser pleas—of a mis-

* See Editor's note at end of article.

demeanor instead of a felony—from small sellers whose principal crime is their own addiction to drugs.

A thorough study of the reports stemming from the operation of narcotic clinics from 1919 to 1923 was undertaken by a committee of the Council on Mental Health and Narcotics in 1955. The establishment of these clinics was highly criticized. However, after cutting through a morass of conflicting statements, the Committee came to the conclusion that the reports were prejudiced and biased. The allegedly detrimental results from those clinics (that they increased the traffic in drugs) seemed to be based largely on opinions of police officers. The narcotics committee felt the clinics never had a chance to establish their true worth and value.

Relation to Morals and Crime

1. Opiates, in themselves, do not cause physical decay or degeneration of the moral fiber. It is only when the addicted person is forced to seek his drugs from underworld sources that criminal acts follow.

2. The crimes of addicts are usually directed against property (theft and robbery), rather than crimes against persons (assault, rape, etc.).

3. Opiates, in themselves, do not incite persons to violent crimes which they would not commit without the drug. Some criminals use opiates. This is not evidence that the drug caused antisocial acts. Narcotics deaden rather than create aggressive drives. The antisocial acts committed result from the need to obtain the means to allay the symptoms caused by their physiologic need for narcotics.

Physiologic Aspects

Recent biologic and chemical studies emphasize that the narcotic drugs are intimately related to the actual metabolic activities of the human cell. Many drugs (which have previously been felt to be addicting because of an emotional defect in the personality of the sufferer) actually have a *chemical structure which allows them to slip into the chemical functions of the cell itself*. Thus the addict is *physiologically* dependent on the drug. Because of this new biologic need, a real physiological dependence is created. Much medical, as well as psychological, research is sorely needed to clarify all these factors. Physicians must be made free to cope with them.

The legal and medical professions are now being alerted to this national threat and are beginning to grapple with it. An exact definition of the framework wherein police control and medical control functions is needed; and the haziness of the dividing lines must be recognized and clarified.

The addict must be treated, not prosecuted. He is to be recognized as an ill person and not as a criminal. Our human understanding and knowledge and compassion should be utilized to guide the addict to our hospitals, not to force him into the underworld and eventual disgrace and oblivion. Valuable citizens, capable of much worth can be then salvaged and restored to their proper place in our society.

Editor's note. Dr. Miller says that "the Harrison Act was never intended to keep the ill addict from physician's care". While the author is entitled to his opinion, the fact remains that the courts interpret the law. The United States Supreme Court in the *Webb* case (249 US 96) was asked if a physician could provide an addict with sufficient drug to keep him comfortable by maintaining his customary use. The Court's answer was: "to call such an order for the use of morphine a physician's prescription would be so plain a perversion of meaning that no discussion is required". This was in 1919. A year later, in the case of *Jin Fuey Moy* (254 US 189) the Supreme Court said that the Harrison Act did not permit a physician to issue morphine "to satisfy the craving of an addict". And in 1922, in *US v Behrman* (258 US 280) the Court reaffirmed this for the third time, holding that the "wholesale prescribing of a drug to an addict, regardless of the doctor's good faith" was a violation of the Act. The U. S. Supreme Court, like all tribunals made up of men, might, of course, be wrong. Still, it seems unfair to say that this Court was guilty of distortion of the law and misinformation as Dr. Miller does. This subject is more complicated than the author could demonstrate in this brief article. Interested physicians are referred to the inexpensive paperback, "Drug Addiction: Crime or Disease" edited by Alfred Lindesmith and published by the Indiana University Press in Bloomington, Indiana. This is the report of the Joint Committee of the American Bar Association and the American Medical Association, together with an essay on the subject by Judge Ploscowe, a review of foreign experience by Rufus King, and a listing of important and informative sources of further information. In general, the position taken in this report is like that taken by Dr. Miller in this article, though it recognizes that the matter cannot be solved by simply separating the traffic control function from the function of handling the addict, assigning the former to the police and the latter to physicians.

2515 Fairlawn Avenue

It used to be said that watchful waiting was all that could be done for a "stroke." But some strokes are due to carotid artery occlusion; and something better than watchful waiting is available.

Carotid Artery Occlusion

A New Diagnostic Technic*

Arthur Winter, M.D.
George Stephans, M.D. / **East Orange**

A simple technic is available to indicate a partial or total occlusion of the carotid artery near its bifurcation. This involves the use of two fingers, using a two-finger technic and provoking a change in the transmitted pulsation when the artery is almost totally occluded at or near the bifurcation of the external-internal carotid. The pulsation may or may not be less as compared to the opposite side by direct palpation. This is a known method of examination, however; compression on the bifurcation with one finger then pressing the common carotid artery to a distance of about 6 centimeters on the

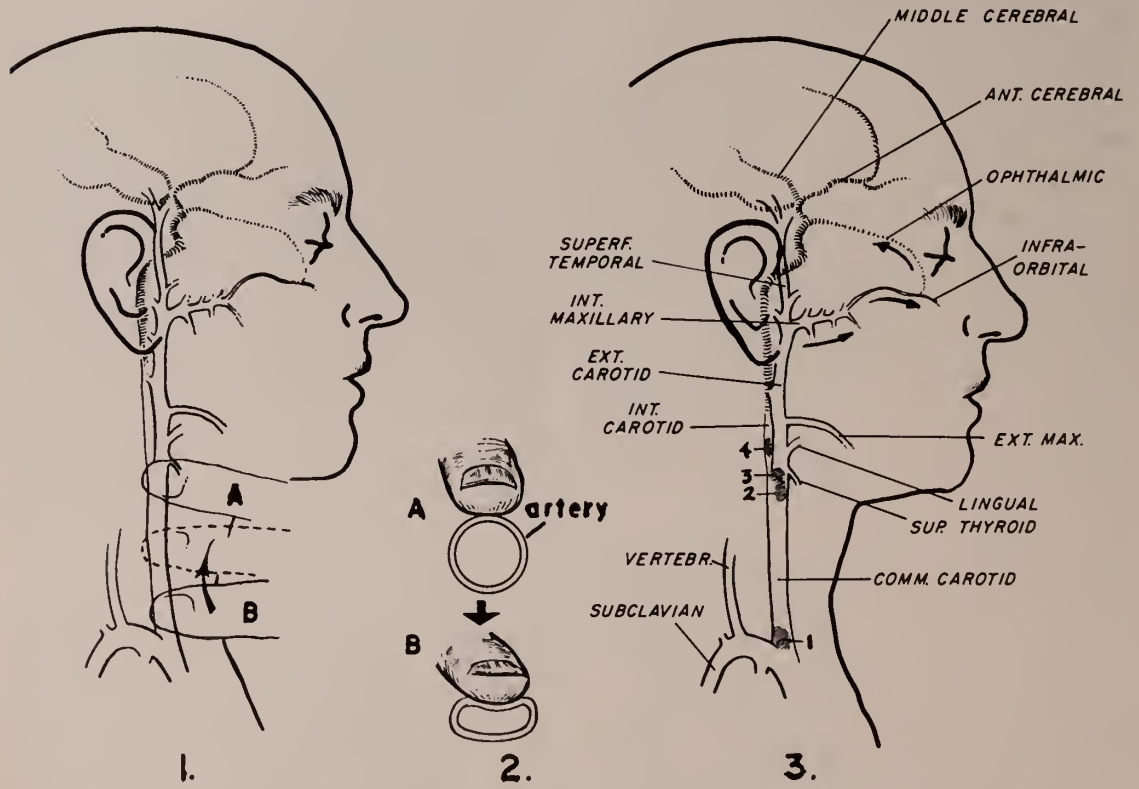


Figure 1. shows the partial compression of the carotid artery where the upper most finger remains stationary (Point A). The lower finger (B) is gradually moving up to obliterate the pulse. A cross section is shown at Figure 2.

Figure 2. indicates only partial compression of the artery (B).

Figure 3. also shows the collateral circulation through the external carotid artery and infraorbital artery to the siphon.

Numbers 1-4 in this figure indicate frequent sites of carotid occlusion where this technique may be utilized.

*From the Veterans Administration Hospital in East Orange, Dr. Winter is attending physician in neurosurgery there, and Dr. Stephans is staff neurologist.



Figure 4. shows total occlusion of the internal carotid artery at the bifurcation (carotid).

proximal portion of the artery; then gradually approaching the finger of the bifurcation, there will be a complete or almost complete obliteration of the pulsation perceived by the finger at the bifurcation.

The pressure applied should be that for partial occlusion since the vessel is already almost totally occluded (see Figure 2).

The analogy made here is that of the production of harmonics on a violin string when the string itself is not pressed completely to the keyboard but is just used to modify the sound transmission. This technic when applied to an artery that is completely patent will cause little or no change on the stationary finger (See Figure 1, position A).

The best of the other methods is the carotid angiogram or retrograde brachial arteriogram which shows the exact site of occlusion and may even show partial occlusion or the development of collateral circulation. This takes no more than a few minutes, needs no special instructions, and is painless to the patient.

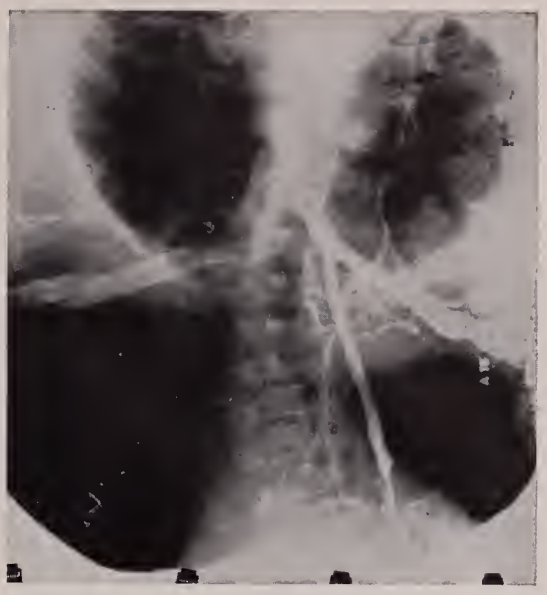


Figure 5. shows total occlusion, the same as in Figure 4 but with axillary catheter in place.

Other available methods include ophthalmologic dynamometry, which is a means of obliterating the pulsation created by the ophthalmic artery and comparing it to the non-occluded side.

Case One

A 44 year-old man was said to have had a stroke. On admission to the East Orange Veterans Administration Hospital, he walked with circumduction of his left lower extremity and had loss of swing of the left upper extremity. He had a left supranuclear 7th nerve paralysis. Motor weakness was noted in extension and flexion of the left ankle and knee, in addition to weakness of the flexor in the left elbow, wrist, and hand. He showed weakness of extension in the left elbow, wrist, and hand and a positive left Barre. Reflexes: superficial, abdominal, cremasterics were present bilaterally. A positive Babinski was present on the left as well as a Hoffman. Deep tendon reflexes are increased in the left upper and lower extremities. He had left ankle clonus. Two point discrimination was positive on the left side.

Previous records from another hospital showed a diagnosis of cerebral thrombosis with left hemiplegia It was also indicated that he had high blood pressure

The provisional diagnosis was cerebral thrombosis associated with arteriosclerosis of the right middle cerebral artery. An angiogram showed an occlusion of the right internal carotid artery at the bifurcation The two-finger test described above was then found to be positive. The patient was explored surgically four weeks later by means of a right carotid thromboendarterectomy and intimectomy. A solid atheromatous plaque and clot were removed *in toto*. On the third postoperative day, he showed slight increased strength in the left leg and has continued to improve up until the present time; a year later

Case Two

A 68-year old right-handed white man suffered from intermittant episodes of aphasia and right hemiparesis. He had a global aphasia, right mimetic central facial paralysis and retinal detachment in the right fundus. There was obvious cerebral insufficiency involving the left dominant hemisphere. Left carotid angiography showed only spasm of the vessels. This man was next seen five months later, at which time he complained of memory impairment and garbled speech, most marked over the past four weeks. He had a central facial paralysis (right) and a right hemiparesis and hypalgesia of the left upper and lower extremities. There was decreased pulsation of the left carotid artery. Left carotid angiogram revealed a plaque in the internal carotid artery (partial occlusion). A left carotid thrombo-endarterectomy was done a few days later. A large plaque was removed. In the immediate post-operative period, he was able to move his right arm and right leg spontaneously. The patient was discharged shortly, to be followed from the office, and has continued to show improvement in his condition to the present time: 6 months after surgery.

Case Three

A 65-year old right-handed man had left-sided seizures. Onset had been sudden. He had a ptosis of the left eye associated with outward deviation of the eye. He was a lethargic, emaciated man with constant tremors of his left arm and leg and left hemiparesis. There was slight left nasolabial droop and decreased pulsation in the right carotid artery; no bruit was heard. Three days later, a right carotid angiogram showed a total occlusion at the bifurcation (See Figures 4 and 5). The patient's family refused further surgery. The obvious occlusion was seen in the x-ray films.

The two-finger test was positive in all cases and all were proved by carotid angiography. These cases demonstrated a simple technic for carotid occlusion which should be followed by more definitive diagnostic studies.

377 South Harrison St. (Dr. Winter)

Tranquilizers Help the Tranquil, Too

"Tranquilizing" drugs show broader effects than previously suspected, according to a June 1964 report by the National Institute of Mental Health, U. S. Public Health Service.

Phenothiazines, the most widely used of the "tranquilizers," improve the passive, withdrawn, apathetic patient even more than the agitated, abusive one. The drugs' action, therefore, is broader and more versatile than is presently outlined in standard medical texts.

This finding was reported by Dr. Jonathan C. Cole, Director of the Institute's Psychopharmacology Service Center, at a Veterans Administration Psychiatric Conference held in June 1964 in Kansas City, Missouri.

His conclusion was based on a study of 340 patients. It showed that the following symptoms which are considered fundamental to schizophrenia are the most improved by the phenothiazines: poor social participation, poor self care, confusion, indifference to environment, and hebephrenic gestures (grimacing and giggling).

Psychiatric teams which evaluated patients with these symptoms after six weeks of drug therapy found them markedly improved. "In contrast," Dr. Cole added, "hostility, agitation, anxiety, and ideas of persecution—symptoms which are usually regarded as 'target symptoms' for tranquilizing therapy—although influenced by the drug treatment, were not affected to as great a degree."

"During the past dozen years," he said, "the phenothiazines have been stereotyped as 'ataractics' or 'tranquilizers,' the implication being that their dominant action is to calm excited patients by relieving the patient's anxiety . . . We have presented evidence to confirm that phenothiazines . . . have a wide variety of clinical effects beyond tranquilization."

The drugs were shown to act in two ways, according to Dr. Solomon Goldberg. They alleviated the patient's pretreatment symptoms, and prevented the development of other schizophrenic symptoms the patient did not have before treatment. The authors conclude that the drugs seem to have a general alleviating and preventive anti-schizophrenic action, and can be used appropriately for a wide variety of schizophrenic patients.

The Medical Coordinator of Passaic County's Civil Defense here presents another view of the CD Program.

In Defense of Civil Defense

William A. Dwyer, M.D./Paterson

Accompanying the following article was a letter from Dr. Dwyer, from which the following has been abstracted.

"This article is in response to Dr. Haun's paper, *A Psychiatrist Looks at Bomb Shelters,* January, 1964 issue of this JOURNAL. Irresponsible articles such as this have made it all but impossible to obtain physician support for the CD program. Papers like this have made it hard to convince any hospital of the necessity of designating fallout shelter areas and of the need for stocking them and planning for their possible use. The additional role of Civil Defense in disaster is also made difficult because of lack of personnel and because of apathy towards anything remotely suggesting CD. On the basis of my own background in this field, I deplore books like *On the Beach* and other harbingers of a final Armageddon. Please print no more of loosely contrived, unresearched essays on Civil Defense matters. A fallout shelter is no fortress or block house. It is an area within an existing structure which will provide a protective factor for the gamma radiation of fallout. This makes possible a tremendous difference in social and economic aspects."

Many eons ago (before August 6, 1945) the world was a very simple place to live in and its problems had simple solutions. Governments could play at power politics as people did at chess.

But this is 1964. The chess set has long ago been put away. The mushroom cloud has forced us into a world where reason and moral suasion rather than naked power are the prime movers of events. World politics is now dominated by the awesome nuclear power of the United States and Russia, held in delicate checkmate. This forces the world into a position where persuasion is the effective instrument of policy—as witness our dispute with little Panama. This prevails, however, only so long as the naked power of the United States exceeds that of Russia, making its use by the latter totally unprofitable.

Part of this "power" is, of course, our nuclear missiles ashore and afloat, as well as the retaliatory capacity of all of our armed forces. Inevitably, however, a small part of this power is our ability, as a country, to survive any initial enemy onslaught, repair the damage done, and provide the necessary continuity both biologically and politically to insure that "This government, conceived in liberty and dedicated to the proposition that all men are created equal shall not perish from the face of the earth."

Let us be quite clear on this: Ideals—no matter how beautiful, noble, or inspiring—survive only in the minds of living men. The perpetuation of ideals requires the existence of men who actively believe in and practice them. The Chinese say that they will win the inevitable struggle between us by the sheer force of their numbers; they will out-survive us.

It is very well to talk about erecting "impregnable barriers to atomic war" through diplomacy and world organizations. Indeed, this country has been attempting just that since the end of World War II. The fantastic lengths we have gone to in this effort are a matter of record in the United Nations proceedings for all of these years. Without a question, these efforts should be continued as vigorously as they have in the past. However, anyone who has taken even a cursory look at what we have offered and what the Communist bloc has turned down can have little doubt as to *their* ultimate goal; or as to what they would do should the opportunity present itself: annihilate us; bury us, as they have blatantly threatened.

Of course we must have a Civil Defense Organization! To be without one would be equivalent to reducing our deterrent capacity, on a par in foolishness to going out in a snowstorm clad in beachwear.

These are difficult times and solutions to problems always seem to end with more problems rather than real solutions. Civil Defense is no different.

If we grant the need, then a number of major problems immediately present themselves:

1. Is it possible to provide any kind of protection against these awesome weapons?
2. How much destruction has to be figured on nationwide? What logistic needs will be required to repair this damage?
3. How to provide maximum safeguard for the entire population with the minimum of disruption of ordinary civilian life? (This problem has economic and sociologic implications, both of which must be considered.)
4. How to create an organization that can provide the appropriate protective, administrative, and rehabilitative support for the period of time necessary, following an enemy attack, to restore a relative degree of ordered existence?
5. How to maintain a level of interest and awareness in the population over a prolonged and indefinite period of time?

Each of these problems has engendered acrimonious debate. Some of this debate has been based on half-truths or vague ideas, as an article in this JOURNAL* has shown.

The truth (based on the Office of Civil Defense estimates recently made available) is that sixteen million Americans would survive an initial strike, provided that no shelter provision of any kind was available. However, this figure can be increased to eighty million by the simple expedient of creating fallout shelters in existing structures. In short, it is possible to provide, at minimum cost, without extensive building construction and with little disruption of normal civilian life, an effective survival potential for one-half of the American populace, should it ever be needed.

The Federal Government has thrown its weight behind planning a fallout shelter program. Extensive efforts are being made to define shelter areas in existing buildings. The plan is to stock these areas with the materials necessary to assure survival of the occupants. *Survival, then, is possible.* Extensive efforts are being made to provide the logistic support it needs.

The Civil Defense Organization has been created to provide for administration and liaison on all levels (Federal, State, and local) prior to, during, and immediately after an attack. Unfortunately, this agency has been pretty much an orphan down through the years. At first, no information on the capacity of the various weapons involved was given to it, so that no real substantive planning for the civilian populace could be undertaken. Then, when information was released on the destructive power of these weapons, the concept of evacuation was developed. This idea took several years to develop. In that interim, the ICBM came into existence, forcing a complete change in overall thinking. These conceptual changes were precipitated by technologic advances in the science of mass destruction. These swift changes may have made Civil Defense appear somewhat ridiculous to the general public. They have also contributed to the general idea that there will be one big bang, and everything and everyone will be exterminated. One small example: on the same day that the papers were headlining the 15 *minute* warning that the new radar system would give us, Civil Defense was trying to work out with the local schools an evacuation system based on a two to three *hour* warning. There is no need to describe the opinions of the school officials.

Since the assignment of this organization to the Department of Defense in the past few years, things have changed slightly for the better. Liaison with the National Guard has been established: the fallout shelter program has been implemented; and many smaller but important phases of Civil Defense have started to come into being. Most of the volunteer workers in Civil Defense (as with volunteer fire departments, ambulance corps, and the like) are motivated by a desire to feel useful to their community and, occasionally, by a knowledge of the importance of this type of work. It is not possible to maintain a level of interest in such an organization without giving

*Haun, Paul: *A Psychiatric Look at Bomb Shelters.* JOURNAL of The Medical Society of New Jersey, 61:3:64.

it something to do. For this reason, an additional role of administrative and logistic support in the event of major disasters was developed for this organization. In this capacity, it has functioned well in numbers of disasters throughout the country, such as the Galveston hurricane, the Philadelphia chlorine gas disaster, and the Connecticut floods, to cite a few. Anyone who has been associated with any kind of major disaster can testify (as did the Mayor of Los Angeles recently) to the need for some over-all co-ordinating agency at such a time. This role has certainly not been fully exploited by Civil Defense to date. As a matter of fact, in view of the repugnance that the topic of Civil Defense seems to engender, it might be wiser if the entire organization was reoriented in terms of disaster control first, with the fallout shelters as a second, equally vital, program, rather than *vice versa*. This would provide the necessary stimulus to hold onto the volunteers and keep interest alive.

Our forefathers made our present possible by plowing their fields with a rifle on their back, by erecting stockades and forts for protection against Indian raids, by drilling as Minute Men; by joining the local militia, by fighting a Civil War, by any number of large and small acts of self-protection. For all of the massive holocaust that threatens us, we must do no less than they and provide ourselves with that amount of self-protection we can reasonably afford, socially and economically. We must additionally ensure that this program is soundly carried out with a minimal disruption of the life we now lead. All of this presupposes that responsible men will acquaint themselves with a knowledge of the situation before writing or speaking on the subject. This would have the salutory effect of providing helpful suggestions and responsible criticism instead of horrifying portents of gloom and unfounded threats of final doom.

It is a terrible thing to contemplate the horrors of nuclear war; but the hazards are there and will be visited upon us should our power falter. Part of this power is our ability to survive such an attack and it must be preserved. We will try to reduce these hazards insofar as we can. But we must also maintain our strengths, until they completely disappear in the hoped for, but far distant, future.

Ideals survive only in the minds and hearts of *living* men.

412 Park Avenue

Reaction to Foregoing

Dr. Paul Haun of Trenton, author of the article which Dr. Dwyer here criticizes, has asked that we publish the following reply.

After what may have been a rather inattentive reading of my January 1964 article on bomb shelters*, Dr. Dwyer has taken me to task for presenting "half truths" and "vague ideas," in a "loosely contrived, unresearched" essay. Since I have two brothers who can lick the stuffing out of any three of his, I will not be offended. It is most certainly true that in my eagerness I did voice several opinions. But if Dr. Dwyer believes these were arrived at by crystal gazing rather than by a dutiful review of the (pardon my expression) "scientific" literature. I wish he had paid my electric light bills for the two months I spent reading it.

He expresses distress and frustration at public apathy and indifference. His tone approaches the plaintive when he says that irresponsible articles like mine make the jobs of those who are planning for Civil Defense unwarrantably hard. So be it Doctor! When my elected representatives try to spend my tax dollars foolishly I will object. When they try to drive all of us underground by reason of a fantastically mistaken interpretation of known fact, I will not only object, I will scream. And have.

Dr. Dwyer endorses our national policy of the credible deterrent; and he personally doesn't trust the Russians an inch. On both counts I

* Haun, Paul: *A Psychiatric Look at Bomb Shelters.* JOURNAL of The Medical Society of New Jersey 61:3 (1964)

am in his corner. I am thoroughly persuaded that there are men in the *Politbureau* who suck eggs and habitually steal kopecks from their grandmothers. I am not as certain, however, that they are mentally defective. And I sincerely believe that however few or many Russian ICBMs are fired at the United States, none will fall, save by the wildest mischance, in the upper reaches of Hudson's Bay. If we *could* count on even a fifty-fifty possibility that all would detonate north of the 70th parallel, perhaps some kind of case could be made by the American Association for Comfy Caves.

I continue to be baffled as to how the doctrine of credible deterrence will be strengthened by a national cobweb of bomb shelters, admitted to be ineffective even by their advocates, against blast and fire storm. These, and not the gentle pitter-patter of "fall out," are the divertisements which Uncle Ivan's megaton lovelies would dispense over radii of 20 to 100 miles from ground zero. The British Institute for Strategic Studies states that Russia has 75 intercontinental missiles able to reach the United States. If an initial salvo zeroed in on the twenty-five American cities having the largest populations, we can predict the resultant deaths at 61 million souls, and no missile warhead would have to exceed ten megatons. Remember there are also those 100 megaton doozies!

Pacing by the worried husband waiting out his wife's first delivery is a harmless and human reaction. I know of no medical evidence that it hastens the relaxation of the cervix or insures the viability of the infant. Unless Dr. Dwyer can offer some of that hard evidence both he and I respect proving that bomb shelters will serve a useful purpose in the event of an atomic holocaust, I shall hold to my opinion that their construction is "busy" work and that we have neither time nor energy to spare from the real job of making nuclear war impossible.

—P. H.

Lupus Nephritis

Your cooperation is requested in a study conducted by the National Institute of Arthritis and Metabolic Diseases to evaluate corticosteroids in lupus nephritis.

Prolonged use of large doses of corticosteroids (50-60 mg prednisone daily) has been effective in controlling the nephritis in selected cases. Since high dosage of the drug often produces severe side effects, moderate dose therapy, if effective in controlling the renal lesion, would be preferable. The major objective of the present study is to compare the relative efficacy of high dosage (50 mg) with moderate dosage (20 mg) corticosteroid therapy. This survey requires a carefully selected group of patients. The diagnosis of SLE must be supported by a positive L.E. preparation. Laboratory evidence of renal involvement is essential but the BUN should not exceed 30. Patients with bleeding disorders, severe thrombocytopenia, psychotic episodes, advanced osteoporosis, and peptic ulcers are not suitable. Patients who are receiving high doses of steroids cannot be accepted.

Those selected will be studied in Bethesda for several weeks. On completion of the baseline studies, the patients will then be started on prednisone and after a period of observation returned to their private physicians who will receive a complete summary.

Physicians interested in having their patients considered for admission to this study should write or telephone:

Dr. Joseph J. Bunim, Clinical Director, National Institute of Arthritis and Metabolic Diseases, Bethesda, Maryland 20014. Telephone: 496-4181 (Area Code 301).

STATE ACTIVITIES

Trustees' Minutes

April 12, 1964

A regular meeting of the Board of Trustees was held on Sunday, April 12, 1964, at the Executive Offices. For the full information of the membership, detailed minutes are on file with the secretary of each component society. A summary of the significant actions follows:

Finance and Budget Committee . . . Approved the report of the Finance and Budget Committee, as follows:

The adopted budget for the current year, expenses from June 1, 1963, through March 31, 1964, and the estimated expenses to the close of the fiscal year, May 31, 1964, were reviewed.

It was noted that a few accounts will show a deficit at the close of the year, while other accounts will show surpluses. A gross balance of approximately $15,500 of unexpended appropriations is anticipated. However, the deficit of THE JOURNAL will be charged off to this unexpended balance and, in consequence, an estimated net deficit of $150 is anticipated. The continuing JOURNAL deficit is influenced by two factors: a decline through the year of 30 per cent in the volume of advertising supplied by SMJAB; and the fact that the advertising rate increase of 65 per cent was not fully effective across the board until March 1964.

All budget accounts and items were individually reviewed and analyzed.

Recommendations:

1. (A-1, B, B-2) That the Board direct the Pension Plan Committee to review and supply a full report on the scope, features, benefits, and annual premiums of the pension plan for all individual employees, with particular attention to the possibility of increasing salary level without increasing pension contribution for the staff member involved.
2. (A-3) That the Board approve the reconstruction of the budget to create general accounts for telephone, postage, and supplies, against which all general charges in these areas will hereafter be made.
3. (A-10) That major medical and surgical coverage for the staff not be included in this budget account at the present time.
4. (A-11) That the budgetary figure for interior repairs and painting ($1,500) be transferred from house reserve to house maintenance (A-5).
5. (C-2) That a reduction of $1,300 be made in the budget of the Council on Legislation to eliminate regularly recurrent budget items which have not been used (auxiliary participation, Legislative promotion and contacts, and extraordinary legal contingent).
6. (C-3) That, insofar as the budget provides a general contingent account, a special contingent of $100 be deleted from this account; that any necessary contingent expenses for the Council on Public Health and its special committees, with the approval of the Board, be charged against the general contingent account.
7. (B) That no provision be made in the 1964-65 proposed budget to offset any anticipated deficit in JOURNAL expenses.
8. That the proposed budget for 1964-65 be approved in the amount of $258,399.50.
9. That the 1965 assessment be adopted at $40 per capita.
10. That the 1964 House of Delegates vote a special per capita assessment of $5, to serve as a contribution to the Medical Student Loan Fund (50%), to the bicentennial fund (25%), and to the Library of the Academy of Medicine of New Jersey (25%); that this per capita assessment apply equally to all dues-paying members, with no reduction for associate members as in the past; that such per capita assessment—if voted by the House—be levied in addition to, and not as part of, the budgetary assessment, with both being paid at the same time.

Legal Counsel . . . Approved the encouraging report of Legal Counsel that the new Deputy Attorney General assigned to the GHI case is convinced of the necessity of his defending the constitutionality of the present statute governing 51 per cent participation in each county.

Seton Hall . . . Directed that the AMA-ERF check payable to Seton Hall College of Medicine and Dentistry be forwarded to Dr. Luke A. Mulligan of Leonia, for presentation to Seton Hall as in other years.

Directed that a contribution of $400 be made to the Seton Hall Student American Medical Association, for the expenses of its two delegates to the national convention in Chicago on April 30.

Memorial to Mrs. Allman . . . Directed that a memorial contribution of $50 be made to the Medical Student Loan Fund in memory of Mrs. David B. Allman of Atlantic City.

Medical Student Loan Fund . . . Recommended that no surplus funds be transferred to the Medical Student Loan Fund for 1963-64, because of currently available funds for this purpose.

Reaffirmed its agreement that the present method of handling Medical Student Loan Fund contributions should be retained.

May 15, 1964

The final Board meeting for 1963-64 was held in Atlantic City on the evening of May 15 at Haddon Hall. For the full information of the membership, detailed minutes are on file with the secretary of each component society. A summary of the significant action follows:

Guides for Physician-Hospital Relationships . . . Unanimously approved the final version of the "Guides"—as submitted by the Council on Medical Services—and directed that they be submitted to the House.

Current State Legislation . . . Approved the positions as recommended by the Council on Legislation, as follows:

*All bills thus marked (*) are identical with the measures of last year—or preceding years—whose positions were the same.

S-171—Permits bioanalytic laboratory testing only by laboratories registered in New Jersey. *No Action*

*S-199—Provides that each offense involving sale or dispensing of narcotics by a person over 21 to a person under 18, after a third offense, shall be punishable by a fine up to $5,000 and 10 years to life imprisonment at hard labor. *No Action*

S-202—Defines as the practice of optometry, subject to regulation, the offering and marketing for retail sale of spectacles or eyeglasses other than plano lenses; exempts a duly licensed ophthalmic dispenser providing spectacles or eyeglasses upon the prescription of an optometrist or physician. *No Action*

S-210—Establishes a Narcotics Advisory Council in the Department of Institutions and Agencies to study, promote, and effectuate a comprehensive plan for the prevention and control of drug addiction, diagnosis, treatment and control of addicts; repeals P.L. 1953, Chapter 449, creating a permanent commission on narcotic control. *No Action*

S-215—Provides for the continued hospital, surgical, medical, and major medical coverage of retired members of the Public Employee's Retirement System. *Approval*

S-235—Amends the law to designate the employment of a child under 18 to transport or sell narcotics as a high misdemeanor. *Approval*

S-236—Amends the law to designate the sale of narcotics by a person over 21 as a high misdemeanor when the sale is for pecuniary gain and tending to corrupt youth. *Approval*

S-237—Prohibits the suspension of a sentence of 20 years at hard labor which is required for a narcotics crime conviction as described in S-236, 1964. *Approval*

*S-249—Permits the licensing of professional nurses
*A-595—at age 18 instead of 20. *Approval*

S-265—Provides that any person convicted as a disorderly person for being under the influence of any narcotic drug not prescribed as treatment for sickness or injury shall forfeit his right to drive for a period of 1 year in addition to the penalty for disorderly conduct. *No Action*

S-276—Clarifies the laws permitting counties, municipalities, school districts, and other public agencies to provide group insurance and hospital and medical services for their officials and employees. *Approval*

*S-282—Amends the Workmen's Compensation law broadly, including provision for maintenance by employers of a panel of physicians to treat injured employees. *Disapproval* . . . in consistency with the declared position of MSNJ in support of free choice of physician.

S-314—Extends provisions of the State Employees
A-676—Health Benefit Act to teachers and other local employee groups; effective July 1, 1964; designated the "Public and School Employees Health Benefits Act." *Approval*

S-315—Creates a 3-member State Board of Chiropractic to supervise and license the practice of chiropractic. *Disapproval* . . . because the public interest is better served by retaining licensure under the control of the State Board of Medical Examiners.

A-218—Regulates the practice of removing superfluous hair from the body through registration and licensing of electrologists by the Board of Medical Examiners. *Disapproval* . . . because it would give electrologists freedom to perform, at their own discretion, procedures which could be inimical to the health and welfare of their patients.

*A-315—Provides that any person who sells any narcotic drug to any person under the age of 21 instead of 18 shall be punished by imprisonment at hard labor for not less than 10 years and no such sentence shall be suspended. *No Action* . . . in view of approval of a higher penalty.

*A-360—Revises the statutes pertaining to production, handling, and distribution of milk, cream, and milk products. *Approval*

A-412—Provides that a person's refusal to the taking of a breath specimen shall justify an inference that an analysis of such specimen would show the presence of an illegal percentage of alcohol in the blood. *Approval*

*A-423—Proposes extensive changes in the rules, regulations, and standards required in licensing of boarding and rest homes. *Approval*

*A-430—Amends the act governing the licensing and regulating of private nursing homes and private hospitals. Provides that "No license shall be granted to a hospital facility unless the Commissioner (Institutions and Agencies) is satisfied that it is adequately prepared to provide all services and care required by the residents of the community wherein it is located." *Disapproval* . . . because the bill is unclear and confers a hazardous grant of power to the Commissioner that could be incompatible with the public interest.

A-559—Permits any county or municipality to establish and maintain a narcotic treatment center. *Approval*

A-568—Provides that if a second conviction of drunken driving occurs 10 or more years after the previous conviction, the court may suspend the jail sentence and impose a fine of not less than $300 or more than $1,000 and place the person on probation; effective on the 91st day after enactment. *No Action*

A-583—Requires places of employment, including

A-626—newspapers, to be constructed, operated, and maintained with reasonable regard to the health and safety of the employees; designated the "Worker Health and Safety Act." *No Action*

A-587—Requires every pupil to be immunized against polio. *Approval*

A-642—Regulates the manufacture, sale and distribution of frozen desserts and special frozen dietary foods; provides for the inspection, sanitation and licensing of frozen dessert plants; provides for the promulgation of standards of identity and definition of frozen desserts and special frozen dietary foods; effective January 1, 1965. *Approval*

A-644—Provides that any person who has served as a sanitary inspector first class in any municipality for a period of 10 years and as executive officer of a municipal board of health for at least 10 years, shall be entitled to obtain a license as a health officer without taking an examination. *Disapproval* . . . because it is special legislation, discriminating against the public interest in favor of an individual.

MSP Board of Trustees . . . Approved the supplemental nomination for submission to the House of Edwin T. Ferren, D.O. of Camden.

MSA Board of Governors . . . Approved the following supplemental nominations for submission to the 1964 House of Delegates:

Joseph I. Echikson, M.D., Newark
Charles W. Barkhorn, M.D., Newark

Performance Survey . . . Approved MSP's conducting a "Performance Survey," in which miscellaneous cases will be checked by forms sent to selected members of the Society—and authorized the President to send a letter to MSNJ members, explaining the confidentiality of the survey and requesting their cooperation with MSP.

Royal A. Schaaf, M.D. . . . Directed that a memorial resolution in memory of Royal A. Schaaf, M.D., be submitted to the House, as the first item of business, following which a moment of silent prayer would be observed.

Seton Hall Application Grant . . . Endorsed for Professor Richard A. Chambers, M.D. of Seton Hall College of Medicine and Dentistry, a Public Health Service grant, for the study of children of normal intelligence who have specific difficulties in the field of reading, writing, and understanding speech.

Non-Profit Mailing Permit . . . Noted that MSNJ has received approval from the post office for a non-profit mailing permit on bulk mailing—which reportedly will save the Society $100 a month on the *Membership News Letter* alone.

Libel and Slander Coverage . . . Suggested that component societies be informed of information received from American Mutual clarifying the television, radio, and publications libel and slander coverage—and the desirability of their taking out separate policies to cover television, radio, and publications, such as MSNJ carries on its Trustees and officers.

Dr. Louis S. Wegryn . . . Gave a rising vote of appreciation and applause to Dr. Wegryn whose term on the Board (as immediate past-president) ended with this meeting.

AMA 7th Delegate . . . Directed that component societies be urged to enlist the additional 150 members in the American Medical Association needed for MSNJ to get a 7th Delegate to the AMA.

May 20, 1964

The reorganization meeting of the Board of Trustees for 1964-1965 was held in Atlantic City on Wednesday morning at Haddon Hall. For information of the membership, detailed minutes are on file with the secretary of each component society. A summary of the significant actions follows:

Elections . . . Elected Dr. Nicholas A. Bertha of Morris County as Chairman of the Board for 1964-65 and Dr. Emanuel M. Satulsky of Union County as Secretary.
. . . Re-elected Dr. Carl N. Ware of Cape May County to the Committee on Finance and Budget, for a three year term (1964-67).

AMA Meeting . . . Authorized the following to attend the June 1964 Annual Meeting in San Francisco, with expenses paid: President, President-Elect, Secretary, Executive Director, and Dr. John F. Kustrup as the alternate delegate.

Salaried Personnel for 1964-65 . . . Re-appointed all salaried personnel not under individual contract, at the salaries set forth in the adopted budget.

Convention Manager . . . Authorized the Administrative Secretary and Convention Manager, Mrs. Edith L. Madden, to attend the meeting of the Professional Convention Management Association—of which she is a board member—in Miami in January 1965.

1964 House of Delegates . . . Directed that the Society's delegates to the American Medical Association present to the AMA House in San Francisco at the Annual Meeting (June 21-25) the following resolutions, which were adopted in May:

1. Rights of Physicians in Hospitals, Resolution #3
2. Implementation of AMA Resolution #68, Resolution #6
3. AMA Membership Opinion Poll, Resolution #8

Cigarette Smoking . . . Directed that the following item from the 1964 House be the subject of a resolution for introduction in the AMA House of Delegates in San Francisco by the New Jersey delegation:

> ". . . that the AMA be more positive in its approach to the cancer problem and smoking; and through state and local societies and individual physicians carry its message to the public. Also, the harmful effects of smoking in conditions other than cancer should be emphasized; for example, in heart disease."

New Jersey Joint Council . . . Agreed that the New Jersey Joint Council to Improve the Health Care of the Aged should be actively continued and that Dr. David Eckstein of Trenton should continue as chairman; authorized an amount up to $500 to offset any approved expenditures of the Council.

New Jersey Medical Assistants . . . Appointed Dr. Henry J. Mineur of Union County as advisor from this Society to the New Jersey Association of Medical Assistants.

Emergency Medical Coverage . . . Directed that the President and Chairman of the Board appoint a committee to meet with the Attorney General and the State Board of Medical Examiners concerning the matter of statewide emergency medical services; further directed that this subject be discussed with county presidents at their meeting in Trenton in October.

Membership Directory . . . Accepted the bid of Printing Corporation of America to print the 1964-65 edition of the *Directory*.

Staff . . . Voted an official commendation to the entire Executive Offices' staff for the "remarkable job" it had done in conjunction with the Annual Meeting.

Sponsors of Resolutions . . . Suggested that any county or delegate who sponsors a resolution at the Annual Meeting should be represented before the proper reference committee by someone well-informed and able to speak in its favor.

Reference Committee Amendments . . . Unanimously agreed that extensive oral amendment of reference committee reports made from the floor of the House is confusing; further agreed that it would be more satisfactory if such amendments were submitted for reproduction and distribution to the House at the time at which reference committee reports are considered; also agreed that (since reference committee reports are usually available through the office the afternoon before their consideration in the House) members interested in a particular report should be given copies in advance, and any member then desiring to make an amendment could proceed as indicated above; directed that well in advance of the 1965 Annual Meeting, component societies be informed of this procedure and be requested to cooperate.

. . . Noted with satisfaction that the procedure governing late introduction of resolutions in the first session of the House initiated by Dr. Jesse McCall (Speaker of the House) had worked so successfully this year; directed that it be continued in succeeding years.

House of Delegates Attendance . . . Directed that the Annual Meeting Committee consider the attendance record of delegates, especially

on the last day of the meeting, and report its findings and recommendations to the Board at a future date; also directed that the Annual Meeting Committee consider the following suggestion concerning the scheduling of meetings next year:

Saturday—First Session of the House
Sunday—Nominating Committee meeting and Reference Committee meetings
Monday—Second Session of the House (Election Session)
Tuesday—Third Session of the House

Agreed that the matter of delegates attendance is the direct responsibility of component societies, who should send only those delegates to the Annual Meeting whom they know to be dependable; directed that the Annual Meeting Committee study and report on the suggestion that delegates be seated in the House in county groups, with identifying signs—as is done by the AMA.

. . . Directed that all the foregoing be discussed with presidents of component societies at their October meeting in Trenton.

Annual Meeting Dates . . . Referred to the Annual Meeting Committee for study and report the suggestion that overall attendance at annual meetings might be better if the convenion were to begin on a Thursday and extend through the weekend, adjourning on a Monday.

Do You Have Any Historical Items?

A review of our two-hundred-year history, as chronicled in the records of The Medical Society of New Jersey, is under way by researchist-writer Mrs. Arlene R. Sayre of Trenton. This material will be compiled and published as part of the Society's bicentennial anniversary in 1966. Dr. Fred B. Rogers, Historian-Archivist of the Society, is professional adviser and consultant for the project.

Papers, illustrations, and other records pertaining to the history of the nation's oldest state medical society will be helpful to this project. Since documents, pictures, and photographs are precious and fragile, arrangements will be made to examine them where they are deposited rather than risking possible damage in the mail.

Such items should be called to the attention of the above compilors by addressing: Dr. Fred B. Rogers, The Medical Society of New Jersey, P. O. Box 904, Trenton 08605.

Committees and Councils

ALTERNATE DELEGATES TO AMA

F. Clyde Bowers, M.D. (1964) ..... Mendham
Frank J. Hughes, M.D. (1964) ..... Gloucester
Joseph R. Jehl, M.D. (1965) ..... Clifton
John F. Kustrup, M.D. (1964) ..... Trenton
John L. Olpp, M.D. (1965) ..... Englewood
Louis S. Wegryn, M.D. (1965) ..... Elizabeth

DELEGATES TO OTHER STATES

Delegates

New York—William F. Costello, M.D. (1965) Dover
Connecticut—Lloyd A. Hamilton, M.D. (1965) ..... Lambertville

Alternates

New York—John W. Holland, M.D. (1965) ..... Margate City
Connecticut—Josiah C. McCracken, Jr., M.D. (1965) ..... Ventnor

SPECIAL COMMITTEES

Disaster Medical Care

Jack R. Karel, M.D., *Chairman* (1965) .... Hillside
R. Winfield Betts, M.D. (1965) ..... Medford
Sidney Ketyer, M.D. (1965) ..... South Orange
Thomas F. Nevins, Jr., M.D. (1965) ..... Linden
Frank L. Paret, M.D. (1965) ..... New Brunswick
Frank R. Schell, M.D. (1965) ..... Butler
Roscoe P. Kandle, M.D., N. J. State Dept. of Health, Trenton, *Consultant*

Medicine and Religion

Jerome G. Kaufman, M.D., *Chairman* (1965) ..... Maplewood
Donald T. Akey, M.D. (1965) ..... Metuchen
John S. Madara, M.D. (1965) ..... Salem
Thomas H. McGlade, M.D. (1965) ..... Camden
Luke A. Mulligan, M.D. (1965) ..... Leonia

Retirement Plan for Physicians

Nicholas E. Marchione, M.D., *Chairman* (1965) ..... Vineland
John J. Bedrick, M.D. (1965) ..... Bayonne
Albert F. Moriconi, M.D. (1965) ..... Trenton
Raphael E. Remondelli, M.D. (1965) .... Belleville

Traffic Safety

William L. Sprout, M.D., *Chairman* (1965) .. Salem
Donald T. Akey, M.D. (1965) ..... Metuchen
R. Winfield Betts, M.D. (1965) ..... Medford
Robert S. Garber, M.D. (1965) ..... Belle Mead
John F. Kustrup, M.D. (1965) ..... Trenton
Ralph E. Siegel, M.D. (1965) ..... Perth Amboy
James H. Spillane, M.D. (1965) ..... Phillipsburg

STANDING COMMITTEES

Annual Meeting

Edward E. P. Seidmon, M.D., *Chairman* (1967) ..... Plainfield
Herschel S. Murphy, M.D., *Vice-Chairman* (1966) ..... Roselle
Milton Ackerman, M.D. (1966) ..... Atlantic City
Thomas M. Kain, Jr., M.D. (1965) ..... Camden
George J. Kohut, M.D. (1965) ..... Perth Amboy
Peter H. Marvel, M.D. (1967) ..... Northfield
Jerome G. Kaufman, M.D. *Consultant* .... Maplewood
Marcus H. Greifinger, M.D., *Secretary* Ex Of ..... Newark

*Scientific Exhibits

Milton Ackerman, M.D., *Chairman* (1965) ..... Atlantic City
Arthur Bernstein, M.D. (1965) ..... Maplewood
Louis K. Collins, M.D. (1965) ..... Glassboro
Thomas K. Rathmell, M.D. (1965) ..... Trenton
Robert E. Verdon, M.D. (1965) ..... Cliffside Park

*Scientific Program

Herschel S. Murphy, M.D., *Chairman* (1965) Roselle

Allergy

William I. Weiss, M.D., *Chairman* ..... Newark
Maclyn Cagan, M.D., *Secretary* ..... Rahway

Anesthesiology

Bernard C. Kaye, M.D., *Chairman* ..... Long Branch
Stephen H. Mazur, M.D., *Secretary* ..... Short Hills

Cardiovascular Diseases

Angelo J. Migliori, M.D., *Chairman* ..... Trenton
Marvin C. Becker, M.D., *Secretary* ..... Millburn

Chest Diseases

Meyer T. Weissman, M.D., *Chairman* ..... Elizabeth
Mervin G. Olinger, M.D., *Secretary* ..... Verona

Clinical Pathology

Raymond E. Conover, M.D., *Chairman* ..... Belmar
S. Raymond Gambino, M.D., *Secretary* .... Englewood

Dermatology

Samuel D. Kaplan, M.D., *Chairman* ..... Elizabeth
Sam Atkinson, M.D., *Secretary* ..... Morristown

Gastroenterology and Proctology

James Edson, M.D., *Chairman* ..... Paterson
Abraham I. Friedman, M.D., *Secretary* .. Hackensack

General Practice

Edward A. Schauer, M.D., *Chairman* .... Farmingdale
Gustave L. Ibranyi, M.D., *Secretary* ..... Newark

Medicine

Elmer J. Elias, M.D., *Chairman* ..... Trenton
Joseph A. Linsk, M.D., *Secretary* ..... Atlantic City

Metabolism

John F. Marshall, M.D., *Chairman* ..... Trenton
Murray D. Shepp, M.D., *Secretary* ..... Trenton

Obstetrics and Gynecology

Eugene J. Slowinski, M.D., *Chairman* ..... Newark
Robert E. Sexton, M.D. *Secretary* .... Point Pleasant

*Subcommittee of the Annual Meeting Committee.

Ophthalmology

Paul H. Pettit, M.D., *Chairman* ..... Ocean City
Anthony M. Sellitto, M.D., *Secretary* .. South Orange

Orthopedic Surgery

Daniel M. Winters, M.D., *Chairman* ..... Red Bank
Robert G. Greene, M.D., *Secretary* ..... Montclair

Otolaryngology

Julio T. Noguera, M.D., *Chairman* ..... Neptune
Thomas F. Flynn, Jr., M.D., *Secretary* .... Woodbury

Pediatrics

Seymour F. Kuvin, M.D., *Chairman* ..... Morristown
Robert Forer, M.D., *Secretary* ..... Trenton

Psychiatry and Neurology

Eugene Revitch, M.D., *Chairman* ..... Plainfield
Arnold M. Kallen, M.D., *Secretary* ..... Newark

Radiology

Philip D. Gilbert, M.D., *Chairman* ..... Camden
John W. Marquis, M.D., *Secretary* ..... Chatham

Rheumatism

Lawrence J. Denson, M.D., *Chairman* .... Hackensack
Georgia E. Allen, M.D., *Secretary* .... Haddon Heights

Surgery

C. Buckman Katzenbach, M.D., *Chairman* ..... Flemington
William E. Philip, M.D., *Secretary* ..... Morristown

Urology

Milton L. Lieberman, M.D., *Chairman* ..... Elizabeth
Robert L. Lieb, M.D., *Secretary* ..... Newark

Credentials

Marcus H. Greifinger, M.D., *Chairman* (Secretary) ..... Newark
Eugene J. Tyrrell, M.D., *Vice-Chairman* (1967) ..... Perth Amboy
William E. Bray, M.D., (1967) ..... Pemberton
S. Thomas Camp, M.D. (1966) ..... Westville
Charles P. Campbell, M.D. (1965) ..... Hackensack
Elton W. Lance, M.D. (1965) ..... Rahway
Raymond A. McCormack, M.D. (1966) .... Trenton

Finance and Budget

Carl N. Ware, M.D., *Chairman* (1967) .. Ocean City
Theodore K. Graham, M.D., *Vice-Chairman* (1966) ..... Paterson
Joseph R. Jehl, M.D. (1965) ..... Clifton
Charles A. Landshof, M.D. (1965) ..... Jersey City
Samuel J. Lloyd, M.D. (1966) ..... Trenton
Vacancy to be filled for 1 year by Board of Trustees 7/19/64 (1965)
Daniel F. Featherston, M.D., *Treasurer* Ex Of ..... Asbury Park

Honorary Membership

F. Clyde Bowers, M.D., *Chairman* (1967) Mendham
Spencer T. Snedecor, M.D., *Vice-Chairman* (1966) ..... Hackensack
David B. Allman, M.D. (1965) ..... Atlantic City

Medical Education

Sherman Garrison, M.D., *Chairman* (1965) ..... Bridgeton
Andrew C. Ruoff, III, M.D., *Vice-Chairman* (1966) ..... Pompton Plains
Louis F. Albright, M.D. (1966) ..... Spring Lake
Frank S. Forte, M.D. (1965) ..... Newark
John W. Nicholson, III, M.D. (1967) .... Moorestown
Morris H. Saffron, M.D. (1967) ..... Passaic
H. Irving Dunn, M.D., *Consultant* ..... Elizabeth

Medical Defense and Insurance

Daniel F. Featherston, M.D., *Chairman* (1967) ..... Asbury Park
Frederick A. Mettler, M.D., *Vice-Chairman* (1966) ..... Greystone Park
Ernest C. Hillman, Jr., M.D. (1966) ..... Newark
Elton W. Lance, M.D. (1965) ..... Rahway
William L. Palazzo, M.D. (1965) ..... Teaneck
Benjamin F. Slobodien, M.D. (1967) .. Perth Amboy
Marcus H. Greifinger, M.D., *Secretary* Ex Of ..... Newark

Medical Student Loan Fund

Luke A. Mulligan, M.D., *Chairman* (1965) .. Leonia
Louis K. Collins, M.D., *Vice-Chairman* (1967) ..... Glassboro
Nicholas A. Bertha, M.D. (1966) ..... Wharton
Frank J. Hughes, M.D. (1965) ..... Gloucester
John F. Kustrup, M.D. (1967) ..... Trenton

Publication

George B. Sharbaugh, M.D., *Chairman* (1966) ..... Trenton
C. Spencer Davison, M.D. (1967) ..... Salem
James J. Fitzpatrick, M.D. (1965) ..... Trenton
John J. Bedrick, M.D., *President-Elect* Ex Of ..... Bayonne
Marcus H. Greifinger, M.D., *Secretary* Ex Of ..... Newark
Henry A. Davidson, M.D., *Editor* Ex Of ..... Cedar Grove

Revision of Constitution and Bylaws

Louis F. Albright, M.D., *Chairman* (1965) ..... Spring Lake
Joseph M. Gannon, M.D., *Vice-Chairman* (1965) ..... Plainfield
Sherman Garrison, M.D. (1967) ..... Bridgeton
John A. Smith, M.D. (1966) ..... South River
John J. Thompson, M.D. (1966) ..... Caldwell
Robert E. Verdon, M.D. (1967) ..... Cliffside Park
Marcus H. Greifinger, M.D., *Secretary* Ex Of ..... Newark

Woman's Auxiliary Advisory

George O. Rowohlt, M.D., *Chairman* (1966) Dumont
Keith R. Young, M.D., *Vice-Chairman* (1967) ..... Burlington
Ralph K. Bush, M.D. (1965) ..... Merchantville
Edward M. Coe, M.D. (1967) ..... Cranford
Thomas H. McGlade, M.D. (1965) ..... Camden
Volmar A. Mereschak, M.D. (1966) .... Phillipsburg

ADMINISTRATIVE COUNCILS

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A. Guy Campo, M.D., *Vice-Chairman* (1967) ..... Westville
C. Byron Blaisdell, M.D. (1965) ..... Asbury Park
William E. Bray, M.D. (1965) ..... Pemberton
Charles L. Cunniff, M.D. (1965) ..... Jersey City
Winton H. Johnson, M.D. (1966) ..... Hackensack
John S. Madara, M.D. (1966) ..... Salem
Henry J. Mineur, M.D. (1966) ..... Cranford
Robert E. Murto, M.D. (1967) ..... Trenton
Nathan J. Plavin, M.D. (1967) ..... N. Bergen
Leonard Rosenfeld, M.D. (1967) ..... Ringoes
Ludwig L. Simon, M.D. (1965) ..... Newark
Nicholas A. Bertha, M.D., *Chairman, Board of Trustees,* Ex Of ..... Wharton

Medical Services

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Nicholas E. Marchione, M.D., *Vice-Chairman* (1965) ..... Vineland
Francis J. Benz, M.D. (1965) ..... Chatham
Harry R. Brindle, M.D. (1966) ..... Asbury Park
Leonard Brown, M.D. (1967) ..... Hackensack
Frederick W. Durham, M.D. (1965) .... Haddonfield
Karl T. Franzoni, M.D. (1967) ..... Trenton
Frank M. Galioto, M.D. (1966) ..... Bloomfield
Joseph M. Gannon, M.D. (1967) ..... Plainfield
Charles B. Norton, Jr., M.D. (1966) .... Woodstown
I. Edward Ornaf, M.D. (1966) ..... Camden
Andrew C. Ruoff, III, M.D. (1967) Pompton Plains
John J. Bedrick, M.D., *President-elect* Ex Of ..... Bayonne

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John B. Fuhrmann, M.D., *Chairman* (1965) ..... Flemington
John P. Coughlin, M.D., *Vice-Chairman* (1966) ..... Jersey City
Edwin H. Albano, M.D. (1967) ..... East Orange
Roslyn Barbash, M.D. (1967) ..... Teaneck
Charles Cunningham, M.D. (1966) ..... Vineland
Anthony P. DeSpirito, M.D. (1965) .. Neptune City
Elmer J. Elias, M.D. (1967) ..... Trenton
Robert S. Garber, M.D. (1965) ..... Belle Mead
Peter J. Guthorn, M.D. (1966) ..... Neptune City
Marion F. Kaletkowski, M.D. (1967) ..... Clifton
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Carl J. Records, M.D. (1966) ..... Cape May
Joseph R. Jehl, M.D., *1st Vice-President* Ex Of ..... Clifton
Roscoe P. Kandle, M.D., Commissioner, N. J. State Dept. of Health, *Consultant*

Public Relations

John F. Kustrup, M.D., *Chairman* (1965) .. Trenton
Harry F. Suter, M.D., *Vice-Chairman* (1967) ..... Penns Grove
George E. Barbour, M.D. (1967) ..... Somerville
Norman K. Boudwin, M.D. (1967) ..... Beverly
F. Clyde Bowers, M.D. (1967) ..... Mendham
S. William Kalb, M.D. (1965) ..... Newark
Carroll M. Leevy, M.D. (1966) ..... Jersey City
Josiah C. McCracken, Jr., M.D. (1966) .... Ventnor
William P. Mulford, M.D. (1965) ..... Beverly
Howard C. Pieper, M.D. (1965) ..... Keyport
Francis I. Tomlins, M.D. (1966) ..... Ridgewood
Earl L. Warren, M.D. (1966) ..... Paterson
Louis K. Collins, M.D., *2nd Vice-President* Ex Of ..... Glassboro

SPECIAL COMMITTEES TO THE ADMINISTRATIVE COUNCIL ON PUBLIC HEALTH

Cancer Control

John L. Olpp, M.D., *Chairman* (1965) .. Englewood
Conrad M. Bahnson, M.D. (1965) ..... Jersey City
William E. Bray, M.D. (1965) ..... Pemberton
George L. Erdman, M.D. (1965) ..... Summit
Roy T. Forsberg, M.D. (1965) ..... Westfield
Sylvan E. Moolten, M.D. (1965) .... Highland Park

Child Health

Robert E. Jennings, M.D., *Chairman* (1965) ..... S. Orange
Neil Castaldo, M.D. (1965) ..... Cranford
William J. Farley, M.D. (1965) ..... Nutley
Thomas F. X. Lenihan, M.D. (1965) .... Ridgewood
David R. Lyons, M.D. (1965) ..... E. Orange
Bernard N. Millner, M.D. (1965) ..... Trenton
Sydney Tucker, M.D. (1965) ..... Perth Amboy
Alice D. Tyndall, M.D. (1965) ..... Red Bank
Geoffrey W. Esty, M.D., Div. of Health, Safety & Physical Education, N. J. State Dept. of Health, *Consultant*

Chronically Ill and the Aging

Matthew E. Boylan, M.D., *Chairman* (1965) ..... Jersey City
Melvin J. Andrews, M.D. (1965) ..... Pennsauken
David Eekstein, M.D. (1965) ..... Trenton
William H. Hahn, M.D. (1965) ..... Newark
William D. Kimler, M.D. (1965) .... Haddon Heights
Thomas E. Mattingly, Jr., M.D. (1965) Mount Holly
Johannes F. Pessel, M.D. (1965) ..... Trenton
Abram L. Van Horn, M.D. (1965) ..... Far Hills
James E. Butler, M.D., *Consultant* ..... Trenton
David B. Allman, M.D., *AMA Representative* ..... Atlantic City

Conservation of Hearing & Speech

James H. Spillane, M.D., *Chairman* (1965) ..... Phillipsburg
Edgar P. Cardwell, M.D. (1965) ..... East Orange
Warren E. Crane, M.D. (1965) ..... Trenton
Arthur Dintenfass, M.D. (1965) ..... Atlantic City
Casimir F. Gadomski, M.D. (1965) ..... Elizabeth
Otto S. Hensle, M.D. (1965) ..... Haekensaek
Julio T. Noguera, M.D. (1965) ..... Neptune
Robert F. Roh, M.D. (1965) ..... East Orange
Aris M. Sophocles, M.D. (1965) ..... Trenton

Conservation of Vision

Ralph E. Siegel, M.D., *Chairman* (1965) ..... Perth Amboy
Henry Abrams, M.D. (1965) ..... Princeton
Domenie Angiuoli, M.D. (1965) ..... Orange
Alfonse A. Cinotti, M.D. (1965) ..... Jersey City
Samuel M. Diskan, M.D. (1965) ..... Atlantic City
William H. Hahn, M.D. (1965) ..... Newark
Joseph H. Kler, M.D. (1965) ..... New Brunswiek
Oram R. Kline, Jr., M.D. (1965) ..... Camden
Robert E. Murto, M.D. (1965) ..... Trenton
D. Blair Sulouff, M.D. (1965) ..... Morristown
Frank B. Vanderbeek, M.D. (1965) ..... Paterson
John T. Worcester, M.D. (1965) ..... Englewood

Maternal and Infant Welfare

John D. Preece, M.D., *Chairman* (1965) .... Trenton
Mary Bacon, M.D. (1965) ..... Bridgeton
Robert A. Cosgrove, M.D. (1965) ..... Jersey City
Henry D'Agostin, M.D. (1965) ..... Wyckoff
Frederick J. Faux, M.D. (1965) ..... Woodbury
Edward Foord, M.D. (1965) ..... Burlington
Theodore K. Graham, M.D. (1965) ..... Paterson
Henry L. Hermann, M.D. (1965) ..... Phillipsburg
Theodore Loizeaux, M.D. (1965) ..... Plainfield
Frank L. Paret, M.D. (1965) ..... New Brunswick
Francis U. Seiler, M.D. (1965) ..... Trenton
Ralph H. Van Meter, M.D. (1965) .... Moorestown
Curtis F. Culp, M.D., Director, Div. of Constructive Health, N. J. Dept. of Health, *Consultant*

Mental Health

Robert S. Garber, M.D., *Chairman* (1965) ..... Belle Mead
Harry Diener, M.D. (1965) ..... East Orange
Edward P. Duffy, Jr., M.D. (1965) ..... Nutley
William Furst, M.D. (1965) ..... East Orange
James B. Goyne, M.D. (1965) ..... Trenton
Evelyn P. Ivey, M.D. (1965) ..... Morristown
Nicholas E. Marchione, M.D. (1965) ..... Vineland
J. Lloyd Morrow, M.D. (1965) ..... Passaic
George A. Rogers, M.D. (1965) ..... Camden
Edward A. Schauer, M.D. (1965) ..... Farmingdale
Martin H. Weinberg, M.D. (1965) ..... Hammonton

Rehabilitation

Elmer J. Elias, M.D., *Chairman* (1965) .... Trenton
E. Vernon Davis, M.D. (1965) ..... Mt. Holly
Robert F. Dow, M.D. (1965) ..... North Caldwell
William G. Kuhn, Jr., M.D. (1965) .. New Brunswick
Thomas F. McLaughlin, M.D. (1965) .... Metuchen
Robert J. Neville, M.D. (1965) ..... Haekensack
James B. Butler, M.D., *Consultant* ..... Trenton

SPECIAL COMMITTEES TO THE ADMINISTRATIVE COUNCIL ON MEDICAL PRACTICE

Occupational Health

Delma W. Caldwell, M.D., *Chairman* (1965) Linden
Lloyd A. Hamilton, M.D. (1965) ..... Lambertville
Edmund M. Hartmann, M.D. (1965) .. Bound Brook
Willis B. Mitchell, M.D. (1965) ..... Toms River
William D. Van Riper, M.D. (1965) New Brunswick
Mathilda R. Vaschak, M.D. (1965) .. New Brunswick

Workmen's Compensation

Joseph A. Lepree, M.D., *Chairman* (1965) ..... Elizabeth
William J. D'Elia, M.D. (1965) ..... Spring Lake
George A. Glass, M.D. (1965) ..... Somerville
William G. Kuhn, Jr., M.D. (1965) New Brunswick
Sanford Lewis, M.D. (1965) ..... Newark
Carl A. Maxwell, M.D. (1965) ..... Phillipsburg
William E. Mountford, M.D. (1965) ..... Trenton
William P. Mulford, M.D. (1965) ..... Beverly
Andrew C. Ruoff, III, M.D. (1965) Pompton Plains
Ralph A. Young, M.D. (1965) ..... Linden
Joshua N. Zimskind, M.D. (1965) ..... Trenton

ANNOUNCEMENTS

Program in Advanced Ophthalmology

Ophthalmologists of New Jersey are reminded of the traditional and distinguished series of graduate courses made available every fall by the New York Eye and Ear Infirmary. This year the series is held from September 7 through November 14. All aspects of advanced ophthalmology are covered. For a detailed catalogue, write to Mrs. Tamar Weber, Eye and Ear Infirmary, 218 Second Avenue, New York, N. Y. 10003.

Hypnosis Course in Philadelphia

Starting October 7, 1964, a graduate course in hypnosis is offered to physicians by the University of Pennsylvania. For details write to Department of Psychiatry, Graduate School of Medicine, 111 North 49 Street, Philadelphia 39. Sessions will be held on Wednesday afternoon, October 7, and every Wednesday thereafter for 20 meetings.

General Office Psychiatry

The Pennsylvania Hospital offers a course in psychiatry for nonpsychiatric physicians focused on emotional aspects of everyday office medicine. The meetings will start on October 7, and be held every Wednesday thereafter for 12 consecutive sessions. For more details, write to The Institute, Pennsylvania Hospital, 113 North 49 Street, Philadelphia 39.

Course in Microsurgery

Each month at the Temple University Medical Center (Philadelphia), an intensive one-week course is offered in temporal bone microsurgery. For information write to Chairman, Department of Otorhinology, Temple University Medical Center, 1400 Ontario Street, Philadelphia.

Medical Hypnosis Course in New York

On seven consecutive Saturdays, beginning on October 3, Columbia University's College of Physicians and Surgeons will make available (to physicians only) a course in medical hypnosis. The instructor will be Herbert X. Spiegel, M.D. and the course will include lectures, case presentations, moving pictures, seminars, and even practice sessions. Tuition fee is $175 and registration is, of course, limited. For more details, write to Assistant Dean, College of Physicians and Surgeons, 630 West 168 Street, New York City 10032.

Emotional Aspects of Racial Strife

November 21 and 22 this year will be the occasion for a colloquium on emotional aspects of racial strife. Sponsored by the psychiatric societies of New Jersey, Pennsylvania, Connecticut, and Delaware, the session will be at the Bellevue Stratford in Philadelphia.

For more details, write to Dr. Philip Mechanick, Philadelphia Psychiatric Center, Monument Avenue at Ford Road, Philadelphia, Pennsylvania, 19131. If you would like to offer a paper on this topic, write to Dr. H. K. Fischer, Coulter Street at Greene Street, Philadelphia, Pennsylvania, 19144.

Booklet On Brain Injury

A brochure about children with minimal brain damage has been issued by the National Society for Crippled Children and Adults. Entitled *Children with Minimal Brain Injury,* the booklet features papers at a symposium on the brain injured child.

The booklet is beamed at teachers, pediatricians, neurologists, ophthalmologists, otolaryngologists, audiologists, speech pathologists, psychologists, psychiatrists, scientists, speech therapists, social workers, and other persons in the medical, child development, and family counseling fields.

Copies of *Children with Minimal Brain Injury* are available at 50 cents from the National Society for Crippled Children and Adults, 2023 West Ogden Ave., Chicago, Ill. 60612.

OBITUARIES

Dr. Abraham Alexander

On April 30, 1964, death came to Dr. Abraham Alexander, one of Newark's senior physicians. Born in 1886, he received his M.D. at Bellevue in 1908. He came to Newark in that year and opened an office for general practice. For more than a half century, Dr. Alexander served the people of Newark. He had staff affiliation at the Presbyterian Hospital in that city and at the Orange Hospital Center. In the 1920s, he was active in committee work for the Essex County Medical Society. In 1958 he was a laureate of our State Society's Golden Merit Award.

Dr. Lydia B. Hauck

New Jersey lost one of its leading women physicians on June 12 with the death on that day of Lydia Bauer Hauck. A general practitioner, she was a golden merit laureate of our Society last year, and in 1958 was designated Woman of the Year by the New Jersey Women's Medical Association. Born in Newark in 1886, she received her M.D. at the Women's Medical College of Philadelphia in 1914. Completing her internship the following year, she accepted appointment as physician to a girls residential school in Richmond, Va. When the United States entered World War in 1918, Dr. Bauer —as she then was—accepted an appointment with the U. S. Public Health Service—one of the first women to be commissioned in that corps. This was followed by several years of private practice in Georgia; then marriage to Dr. William Hauck. She returned to her native state, and shared offices in Irvington with her husband from 1923 until her death.

She was active in civic and church affairs, and was one of the founders of the Irvington Child Guidance Association.

Dr. William Matthews

A heart attack on May 12, 1964 took the life of Dr. William Matthews, a Monmouth County otolaryngologist. Born in Red Bank in 1896, he received his M.D. at the Jefferson Medical College in 1923. In Brown University, which he attended from 1921 to 1925, he was a star baseball pitcher on the Varsity team. Dr. Matthews did graduate work in ophthalmology and otolaryngology in Spain and in Austria. In two months in 1952, he served the American Mission in Pakistan where he did over a thousand cataract operations. He was director of otolaryngology at the Riverview Hospital in Red Bank and a consultant at both hospitals in Long Branch. He also served a term as chief of staff in the Riverview Hospital.

Emma W. Metzer, M.D.

Ulysses Grant was President of the United States when Emma Metzer was born in 1870. And on April 7, 1964 she died at the grand age of 94. At the age of 23, she received her M.D. from the Women's Medical College of Philadelphia. She then crossed the Delaware and returned to her native Riverside in Burlington, N. J. to practice. She remained in active, versatile and vigorous general practice until her retirement at the age of 70. She was affiliated with both the Zurbrugg Hospital in Riverside and the County Memorial Hospital in Mount Holly.

R. Browning Wilson, M.D.

A brother of the ex-governor of Virginia, Stanley Wilson, our fellow-member, Dr. R. Browning Wilson, died at his brother's home in Virginia on April 13, 1964 at the age of 90. Born in Vermont, he was graduated from his state university's medical school in the class of 1897. He came to Monmouth County to practice, and served Red Bank's Riverview Hospital in all levels of staff work, eventually becoming chief of staff there. He was also a consultant at the Monmouth Memorial Hospital. In 1957 he was a laureate of our Society's Golden Merit Award.

BOOK REVIEWS

The Immunology of Rheumatism. By J. B. Kwapinski, M.D. and M. L. Snyder, Ph.D. New York, 1962, Appleton Century-Crofts. Pp. 255. ($9.00)

The complex, often confusing, and ever-expanding subject of immunology in rheumatic diseases is here exhaustively explored through experience gained from more than 50,000 serologic tests.

The text successively explores the various types of streptococcal antigens, antibodies, cellular and tissue reactions, and auto-immune processes which have been associated with rheumatic states such as rheumatic fever, rheumatoid arthritis, lupus erythematosus, scleroderma, and fibrositis.

The authors believe in a strong relationship of the immunologic rheumatic process to hemolytic streptococci. The latter are theorized to have opened the entrance for unknown "etiologic agents" of rheumatism. They constantly point out the many areas of new exploration and the possible sources of future benefit in this field of study.

A major part of this book is devoted to detailed discussions of the serologic methods and their position in the rheumatic process. These include some of the better known tests as the antistreptolysin titres, latex fixation, L-E tests, and C-Reactive proteins—to mention a few. A final chapter considers the potential application of the immunologic reactions in clinical states.

This text will ably serve the investigator, pathologist, or rheumatologist as a reference book since it is detailed and extremely technical. It will have a limited value for the general medical public, because it is too detailed and "theoretical". However, as a reference it is of immeasurable value. With these limitations, I recommend this book to all interested physicians. Irving L. Sperling, M.D.

Diabetes and Its Long Range Control. By Arthur Krosnick, M.D. Medical Film Guild, 1962, New York. Pp. 41. Illustrated. ($1.00)

This booklet is a supplement to an excellent film on diabetes sponsored by the New Jersey State Department of Health. This brochure is a veritable gold mine. It is designed primarily for the general practitioner who wishes to review, in the shortest possible time, the latest information available on diabetes. In a didactic style (dictated by the small space available), without going into controversial issues, it discusses glucose metabolism, heredity, approach to therapy of the juvenile and adult type of diabetes, the diet—as well as insulin and oral hypoglycemic agents, acidosis, and diagnosis. It also introduces the reader to many other syndromes which may be associated with diabetes, and mentions the "so-called complications" of diabetes, such as retinopathy, nephropathy, and vascular disease.

Emphasis is placed on early detection—the methods and follow-up which are so important in bringing the diabetic to the doctor for immediate treatment. Continuity of long-term care is placed in its proper perspective. The reader is then referred to an extensive bibliography for more detailed information.

The author of the pamphlet, Dr. Krosnick, is the Coordinator of the Diabetes Control Program for the New Jersey State Department of Health. Dr. Krosnick is doing an outstanding job in the field of diabetes detection, which is being acknowledged by Public Health Agencies throughout the nation. Otto Brandman, M.D.

Gynecology. Langdon Parsons, M.D. and Sheldon C. Somers, M.D. W. B. Saunders, 1962, Philadelphia. Illustrated. Pp. 1250. ($20.00)

This book is unique in its arrangement and offers a welcome addition to the gynecologist's library. It includes 73 chapters dealing with subdivisions within each age group. It starts with gynecologic problems of infancy and childhood; then to adolescence, and subsequently to the young woman age 20 to 30; finally through

the decades of life to gynecologic problems in old age. This grouping makes the text useful to a practicing gynecologist who wishes a chance to use textbook material when faced with a problem in a specific patient. Of course, the material will be misplaced when dealing with the uncommon condition such as endometrial carcinoma in a young woman, endometriosis in a teenager, and the fertility problem in the patient over age 30. Nevertheless, the arrangement of the material does not detract materially from the usefulness.

The paper is of good quality and the print is large and easily read. Many pictures and diagrams illustrate the text. They greatly simplify and amplify the printed matter which is written in a lively conversational vein. For instance, in the chapter on pelvic pain, there are two saggital sections of a woman illustrating the extragenital causes and the other genital causes of the pelvic pain. Each diagram is marked with a star indicating the source of the pain, possible cause of pain, and a notation on the side indicating what the star denotes. In a like manner, the diagram describes the mechanism, the Stein-Leventhal syndrome, and clarifies the mechanism of the amennorrhia and sterility.

Subsections of each chapter are well annotated and are headed in a form to save time when this book is used as a ready reference. Included are key headings, such as: How do you tell the parent and the child?; How do we treat threatened abortion?; How does the disease spread and manifest itself? Such questions in heavy type pinpoint the problem which the clinician will face. The answers are given in a practical manner with sufficient detail to be helpful.

The only gross deficiency in this book is the lack of material on operative gynecology. When surgical intervention is recommended, the names and types of operations are used but technic is not described. However, since this is not a textbook of operative gynecology, this omission does not deter from the general usefulness of the volume.

In general, this book merits an unqualified recommendation as a textbook, therapeutic guide, and ready reference for the busy gynecologist.

Edward Comando, M.D.

Strabismus—Symposium of the New Orleans Academy of Ophthalmology. By R. Berke, M.D. and others. St. Louis, 1962, Mosby. Pp. 369. Illustrated. ($18.00)

This is an informative book by a distinguished panel of experts. It includes a review of basic principles of diagnosis and treatment of common eye muscle problems. This will be of value, not only to the beginner, but also to the more experienced ophthalmic surgeon. Some of the newer concepts, such as the A and V syndrome, receive due recognition. This new dimension in ocular muscle physiology merits the attention of all serious practitioners of eye muscle surgery. In the past symmetrical eye muscle surgery has generally been favored; but it is here pointed out that this may aggravate deviations which are incommitant in the up and down position. Another example of changing trends is evidenced by one member of the panel who treats all exo deviations requiring surgery by recessions on the lateral recti regardless of whether they are greater for near or far. Some 60 pages are devoted to a round-table discussion which raises many of the questions that arise in the daily practice of muscle ophthalmology. This section alone makes this book worth placing in the library of all interested ophthalmologists. The disagreement aired on many subjects makes for lively and informative reading. The ophthalmologist will here find many points and pearls which he can apply in everyday practice. In general, this book is to be recommended.

Edward L. Liva, M.D.

Essentials of Pediatric Psychiatry. By Ruben Meyer, M.D.; Morton Levitt, Ph.D.; Mordecai L. Falick, M.D.; Ben O. Rubenstein, Ph.D. Appleton-Century-Crofts, New York, 1962. Pp. 208. ($6.00)

This short, readable, informative book is written for the physician who deals with children. Not a definitive text on child psychiatry, it highlights the psychophysical development of the child and presents certain viewpoints of special interest to the authors. The reader is rewarded by gaining in familiarity with the

child's emotional development and its complex interaction with physical function. Quite appropriately, the writers deplore the tendency of certain pediatricians to become psychiatrists and *vice versa;* instead, they suggest that there be an increased joint use of the skills of the pediatrician and child psychiatrist.

The first half of the book deals with normal childhood development and problems encountered therein. There follows a particularly helpful section on emotional reactions to trauma and hospitalization. The balance of the book is devoted to the serious disorders of development with a closing short section on psychiatric diagnosis and treatment. Of greatest interest to many readers will be the sections on disturbances of various "systems" of the body, especially autonomic system disturbances and motor disorders. Here, quite properly, the emphasis is placed on the dynamic relationship between unhealthy, emotional development and associated malfunction of both psyche and soma. Possibly it is inevitable that in such a brief consideration of disorders of function there must be oversimplifications both as to etiology and treatment. Such is regrettably the case on occasion. All in all, however, this is a valuable book—enhanced by a clear index and helpful footnotes. Charles R. Swift, M.D.

The Exocrine Pancreas. Normal and Abnormal Functions. By A. V. S. deReuck and Margaret P. Cameron, Editors for the Ciba Foundation. Little, Brown & Company, Boston, 1962. Pp. 390. Illustrated. ($11.50)

This volume is one of a series from the Ciba Foundation Symposia. The articles range from ultrastructure and histochemistry of the pancreas through protein metabolism. Most of the papers are highly technical, but the discussion at the end of each is most useful reflecting significant differences of opinion. Also included is a summation of salient features of the conference with a critical evaluation of various points of view. This is, perhaps, the most useful section for the general practitioner or internist. This concluding chapter agrees that there is nervous control (vagus) of pancreatic secretion; that there is a necessity for standardization of enzyme levels and methodology. There is considerable disagreement on the reliability of the secretin test because standardization of secretin is still unsatisfactory. Those who use the secretin test are convinced that measurement of bicarbonate and volume in exocrine secretion is a dependable index of pancreatic function. Enzyme studies are more reliable with pancreozymin, but the extract of this hormone is impure. Others prefer to measure the level of pancreatic enzymes and biliary constituents during digestion *via* intubation (Börgstrom). Vink prefers the oral gelatin loading test and levels of aminoacidemia as a measure of proteolysis and absorption.

Iontophoresis is suggested for standardizing the sweat test for cystic fibrosis in the adult. Hereditary pancreatitis is associated with aminoaciduria, specifically excretion of lysine and cystine in about 33 per cent. Finally, pancreatic needle biopsies were considered safe and adequate and recommended as a means of correlating function with histology.

A. I. Friedman, M.D.

Transplantation. *Edited by G. E. W. Wolstenholme and Margaret P. Cameron. Boston, 1962, Little, Brown and Company. Pp. 426. 71 illustrations. ($12.00)*

This is a compilation of the remarks of some thirty students of the problems of transplantation, who attended a conference in London in November 1961.

Topics discussed include transplantation antigens, skin pouch homografts in the Syrian Hamster, transplantation tolerance and immunity in relation to age, radiation chimeras, the role of lymphocytes, runting disease, methods of modifying runt disease in mice, and the role of the thymus in transplantation tolerance and immunity.

Is a cell capable of giving cellular response at the same time as it gives a serum response? Dr. Lawrence of the New York University School of Medicine gave the following reply: "The answer to such a question is difficult because of a lack of an *in-vitro* test for detailed hypersensitivity and so far, only an *in-vivo* test

is available to reveal its presence where it has been looked for in relation to scrum antibody formation, delayed allcrgy may precede the appearance of detectable serum antibody. Our complete ignorance of the cell or cells involvcd in introduction, manifestations and transfer of delayed allergy would also engender caution. The lymphocyte has assumed a position of prominence in each phase of dclayed allergy, but it may be more realistic to leave the matter open at this time. The answer is that we do not know".

The crucial importance of the thymus was stressed in the development of immunologic activity. Considered was the possibility that newborn mice can be sensitized. These engendered all kinds of reflections on the relations between tolerance and paralysis.

The reviewer cannot feel that the conference advanced transplantation knowledge, but it did serve as a medium for recording problems pertaining to this activity. The pathology and the pathologic changes encountered in runt disease are well illustrated in Russell's remarks on modifications of runt disease. Students of biology should evidence major interest in this publication. The volume is over-priced.

Thomas K. Rathmell, M.D.

Urology in Medical Practice. Ed. 2. By F. C. Hamm, M.D. and S. R. Weinberg, M.D. Philadelphia, 1962, Lippincott. Pp. 323. 277 Illustrations. ($9.75)

Not often is one afforded the opportunity of reading a book of this character. This second edition is extremely practical. It will be an asset to any library because of its plates and illustrations. The procedures and definitions of urologic terms can easily be followed by the general practitioner. The technic of catheterization and the principles of roentgen diagnosis are clearly demonstrated and interesting. The many anomalies associated with renal conditions and the symptoms accompanying it will relieve a good deal of the confusion in differential diagnosis. It gives the reader a thorough insight into urologic infections and offers recommendations for surgery or other therapy.

In addition, I must remark on the cxcellent organization of the book. The reader can follow the orderly fashion in which x-rays, physical cxaminations, laboratory procedures, and instrumental cxaminations are set down and which arc important portions of this book. Especially interesting arc the chaptcrs pertaining to urologic cxamination in infancy and childhood; thc material on diseases of thc ureter and thcir appendages are thoughtfully presented.

The authors have contributed greatly toward assisting interns and residents as well as the general practitioner. This book can be of invaluable assistance in their study.

R. Lewis McKiernan, M.D.

Electrocardiography. By Louis Wolff, M.D. Third edition. Philadelphia, 1962, W. B. Saunders Company. Pp. 351. Illustrated. ($8.50)

This third edition is almost entirely unchanged from the previous edition; but this does not detract from its excellence. Dr. Wolff uses the concept of the vectorcardiogram in assisting his interpretation of the electrocardiogram; but the casual reader need not be frightened off by this seemingly advanced technic. Vectorcardiograms themselves do not appear in the text except occasionally to explain a point diagrammatically. These are technically simple and readily understandable.

New in this edition is a brief addition to the discussion of bundle branch block. There are several new illustrative electrocardiograms of electrolyte disturbance and an almost entirely revised section on pulmonary embolism. The chapter on ectopic arrhythmias has been revised.

The section of the book on basic electrocardiography is essentially unchanged, and is of interest and value to anyone wishing an understanding of the physiology of the electrocardiogram. It is concise, yet not too curt; elementary, yet of value to generalists and specialists.

This is a fundamental textbook on electrocardiography rccommended to anyone wishing a basic understanding before going on to the more advanced and esoteric texts currently available. Harvey E. Nussbaum, M.D.

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1. Roach, T. C.: Therapy of Peptic Ulcer, J. Louisiana Med. Soc. *115*:136-139 (April) 1963.
2. Steinberg, H., and Almy, T. P., Drugs for Gastrointestinal Disturbances, Chapter 21, in Modell, W. (editor): Drugs of Choice —1964-1965, St. Louis, The C. V. Mosby Company, 1964, p. 343.

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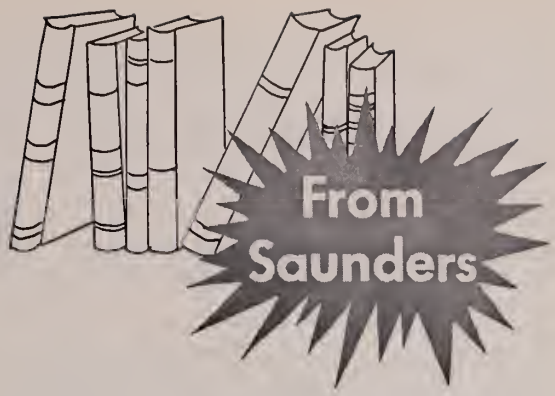
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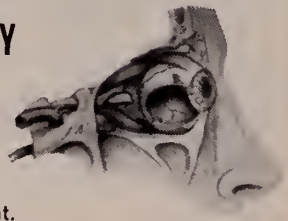


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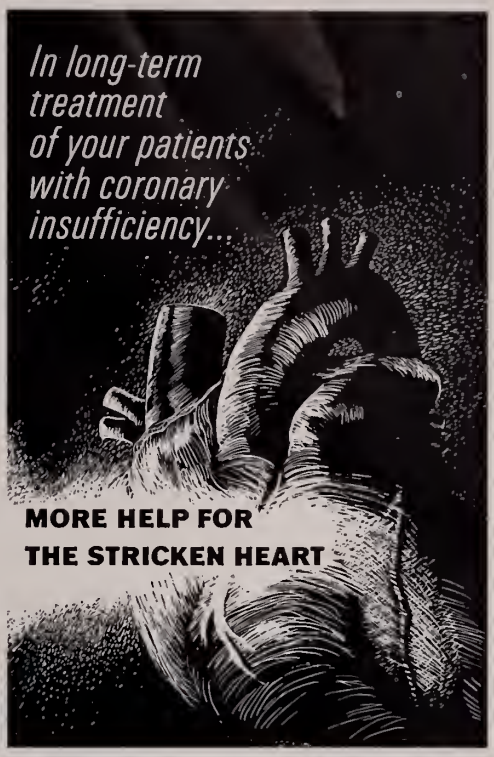
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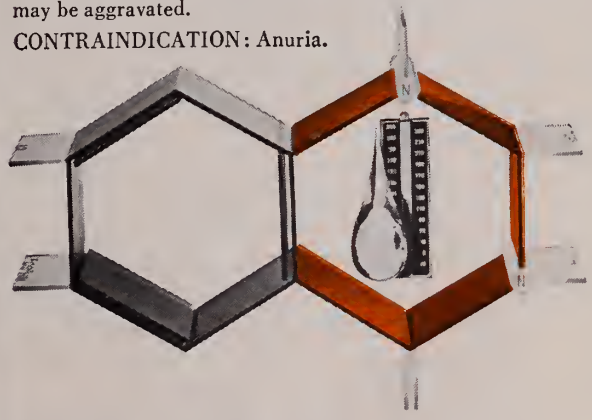
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1. Steigmann, F., and Griffin, R.: Evaluation of Quinethazone, a New Diuretic. *J. Amer. Geriat. Soc.* 11:945 (Oct.) 1963.
2. Schwartz, M.: Office Evaluation of a New Diuretic in Patients with Hypertensive Diseases. Scientific Exhibit Presented at the Clinical Meeting of the American Medical Association, Los Angeles, California, Nov. 25-28, 1962.

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Time: Wednesdays, 9 to 11 A.M. starting September 23, 1964

Beginning this September, a ninth Postgraduate Course open to all physicians will be given under the sponsorship of the Academy of Medicine of New Jersey, the New Jersey State and Middlesex County Chapters of the American Academy of General Practice, and Rutgers Medical School, with the cooperation of Middlesex General Hospital in New Brunswick. The Course will make available information on recent advances in phases of medicine of greatest interest to general physicians and internists. Accreditation will be given toward meeting the requirements of the American Academy of General Practice (University type credit) and of certain phases of hospital educational programs for interns and residents.

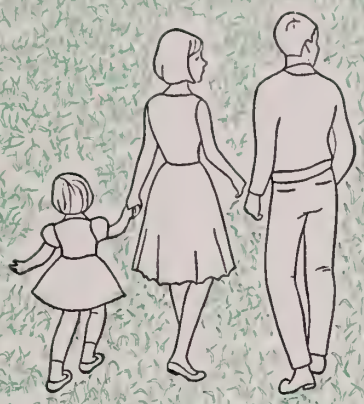
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SEPTEMBER, 1964 Vol. 61, No. 9

The Medical Society of New Jersey

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from pian in Ubangi to tonsillitis in Maine



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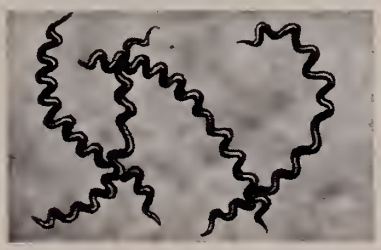
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1. Dorfman, W., and Johnson, D.: *Overweight Is Curable*, New York, The Macmillan Company, 1948, p. 16.

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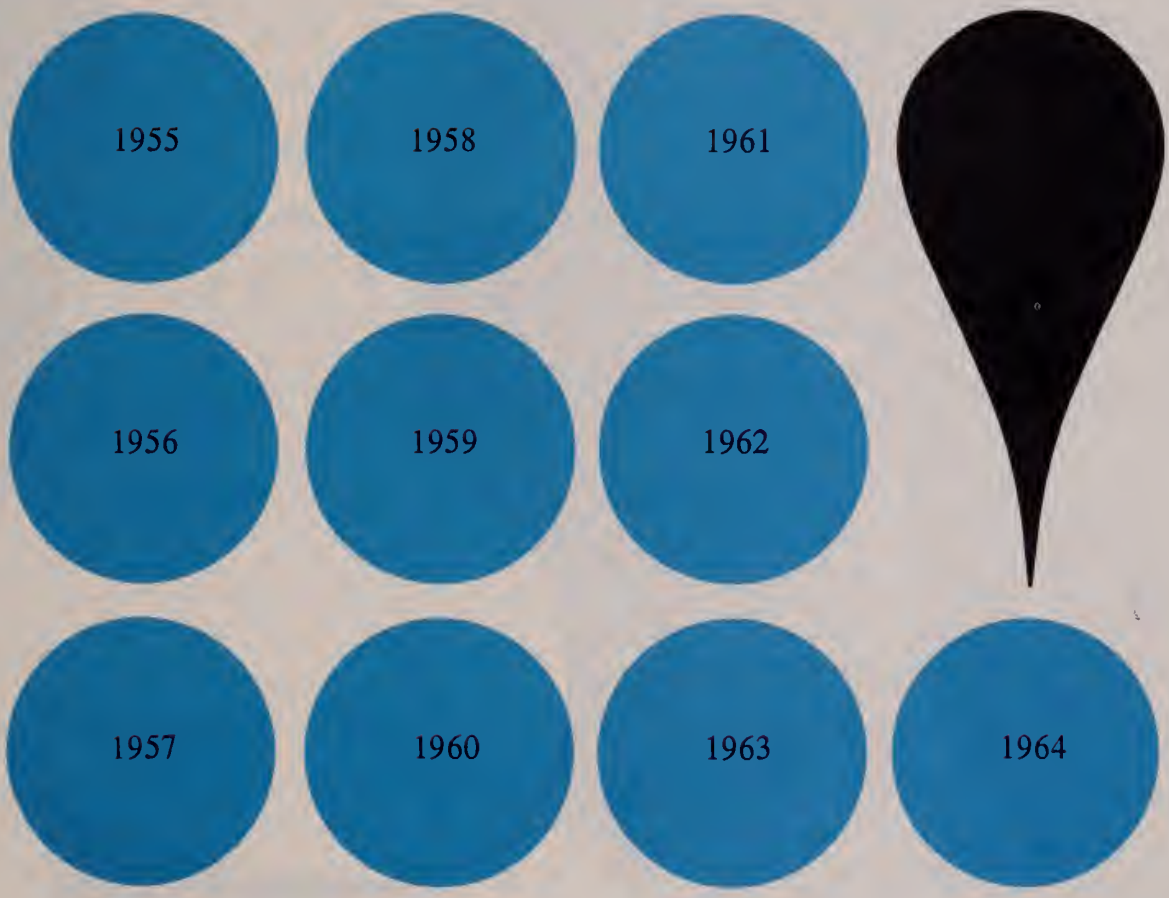
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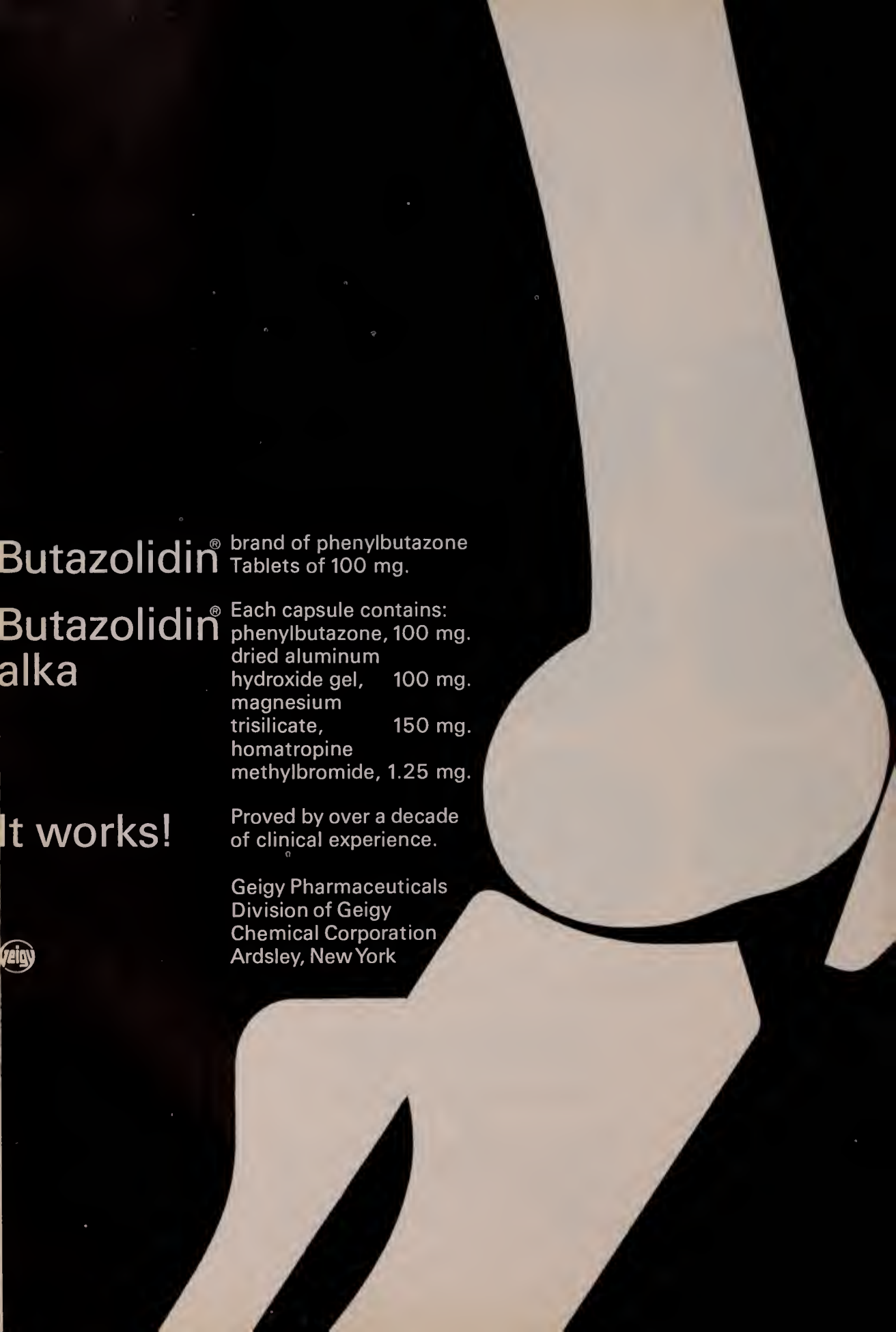


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* AMA Council on Foods and Nutrition: The Regulation of Dietary Fat, *JAMA* 181:411-423 (August 4, 1962).
AMA Council on Foods and Nutrition: Composition of Certain Margarines, *JAMA* 179:719 (March 3, 1962).



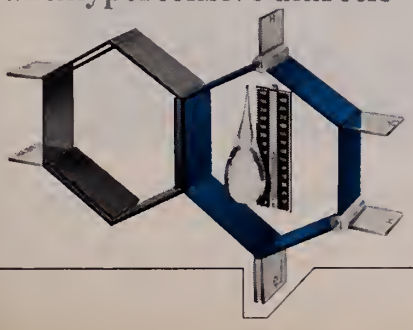
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CONTRAINDICATION: Anuria.

1. Steigmann, F., and Griffin, R.: Evaluation of Quinethazone, a New Diuretic. J. Amer. Geriat. Soc. 11:945 (Oct.) 1963.

2. Schwartz, M.: Office Evaluation of a New Diuretic in Patients with Hypertensive Diseases. Scientific Exhibit Presented at the Clinical Meeting of the American Medical Association, Los Angeles, California, Nov. 25-28, 1962.

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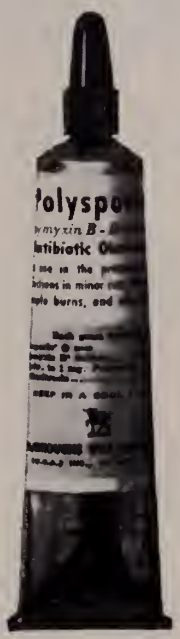
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Dosage: Functional amenorrhea, 5 tablets daily for 5 days. Dysmenorrhea, 1 to 2 tablets daily during the second half of the menstrual cycle, except for the final two days. Dysfunctional uterine bleeding, 5 to 7 tablets daily for 5 days; in mild cases, reduce dose 1 tablet each day.

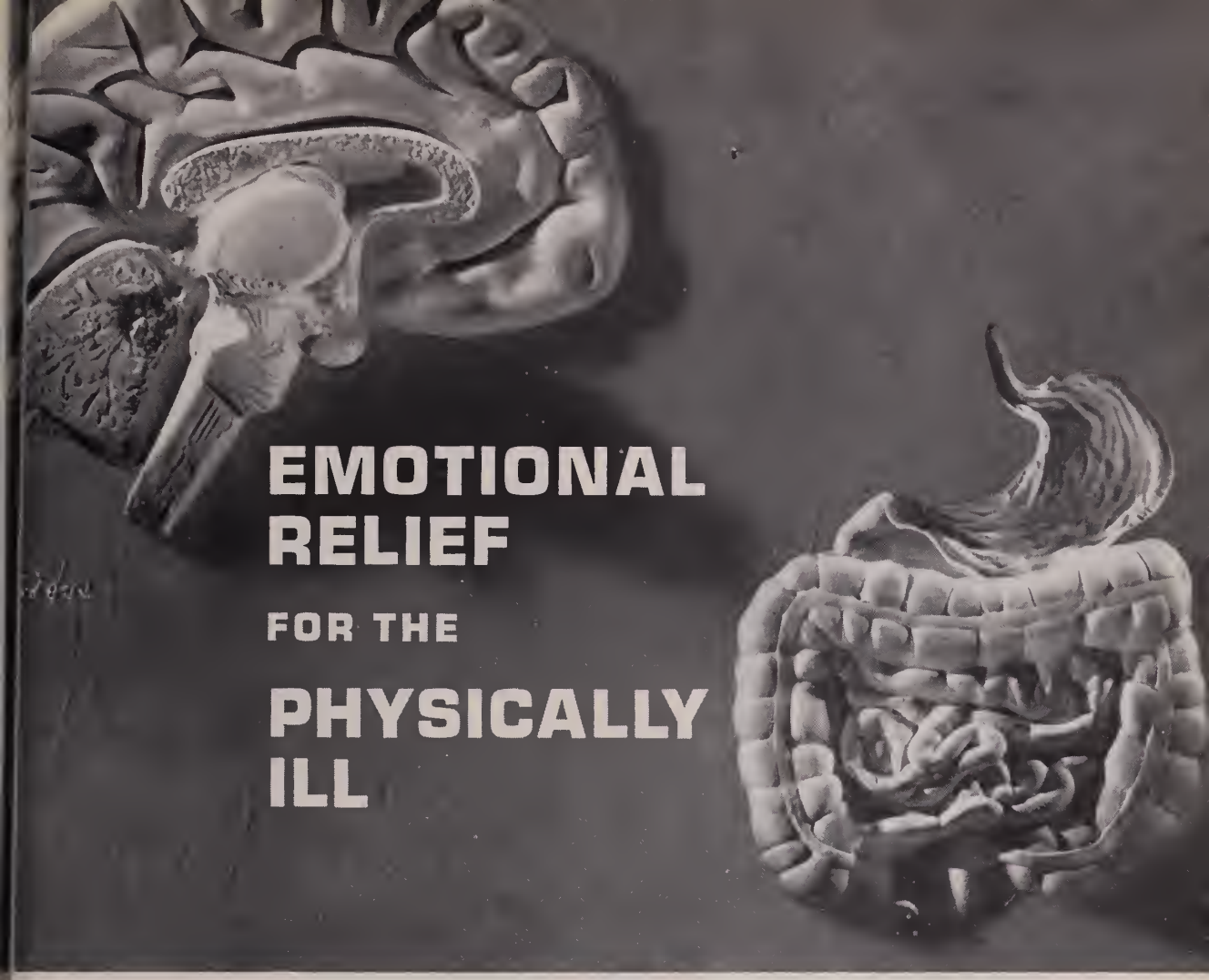
Side Effects: Ethinyl estradiol may occasionally cause headache, diarrhea, engorgement and tenderness of the breasts, nausea, vomiting, cramping, or skin rash. These side effects usually fade as the patient adjusts to the estrogen.

Cautions and Contraindications: DUOSTERONE is contraindicated in carcinoma of the breast and reproductive organs and should be used with caution in cases of known liver impairment.

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le effects: 'Meprospan' (meprobamate, sustained release) remarkably free of untoward reactions. Daytime drowsiness s not been reported. Rare allergic or idiosyncratic reactions ıy occur, generally developing after 1-4 doses of the drug.

ntraindications: Previous allergic or idiosyncratic reactions meprobamate contraindicate subsequent use.

ecautions: Should administration of meprobamate cause owsiness or visual disturbances, the dose should be reduced. peration of motor vehicles or machinery or other activity quiring alertness should be avoided if these symptoms are esent. Effects of excessive alcohol may possibly be increased meprobamate. Prescribe cautiously and in small quantities to patients with suicidal tendencies. Massive overdosage may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after prolonged use at high dosage.

Complete product information available in the product package, and to physicians upon request.

Usual adult dosage: One 400 mg. capsule or two 200 mg. capsules at breakfast; repeat with evening meal.

Supplied: 'Meprospan'-400 (meprobamate 400 mg.), 'Meprospan'-200 (meprobamate 200 mg.), each in sustained-release capsules. Both potencies in bottles of 30.

E-805

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ARTHRALGEN® helps fre





RTHRALGEN®

ch tablet contains:

icylamide	250 mg.
etaminophen	250 mg.
corbic acid (Vitamin C)	25 mg.

thralgen, a better-tolerated analgesic formula- n of time-tested ingredients, works faster to free arthritic from his pain without salicylate side ects. Since its analgesic components require chemical conversion to act in the body, Ar- algen's pain relieving benefits are immediately ailable to provide a smoother, more rapid ob- ndation of pain than can be achieved with many e salicylates.

thralgen is especially useful for the prompt ief of early morning stiffness and pain with less k of gastric irritation. And since Arthralgen ntains no sodium it is safe for long-term use in arthritics who have other conditions which neces- sitate sodium restriction.

ARTHRALGEN®-PR

Each tablet contains:

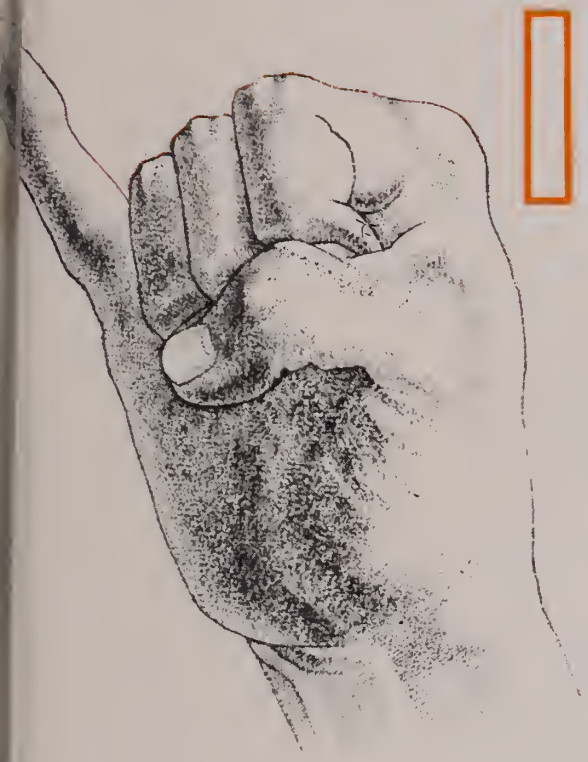
Salicylamide	250 mg.
Acetaminophen	250 mg.
Ascorbic acid (Vitamin C)	25 mg.
Prednisone	1 mg.

The basic Arthralgen formulation plus predni- sone is indicated for patients who require steroids. Prednisone has three advantages over cortisone, hydrocortisone, and ACTH. They are: (1) lack of sodium retention, (2) absence of increased potas- sium excretion, and (3) the unlikelihood of steroid- induced hypertension.*

BRIEF SUMMARY

Arthralgen and Arthralgen-PR are indicated in the management of rheumatoid arthritis, acute

rthritic joints from



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N

outy arthritis, rheumatoid spondylitis, osteoar-
ritis, bursitis, fibrositis, and neuritis. Arthralgen
ay be used for analgesia in colds, flu, and
arious myalgias.

OSAGE: One or two tablets four times a day.
After remission of symptoms, dosage should be
educed to the minimum maintenance level.

IDE EFFECTS: Nausea, GI upset, or mild salicy-
ism may rarely occur. Symptoms of hypercorticoid-
sm dictate reduction of dosage of Arthralgen-PR.

PRECAUTION: Reduction in dosage of Arthral-
gen-PR given over a long period should be gradual,
never abrupt.

CONTRAINDICATIONS: Hypersensitivity to any
ingredient.

As with any drug containing prednisone, Arthral-
gen-PR is contraindicated, or should be adminis-
tered only with care, to patients with peptic ulce
tuberculosis, nephritis, diabetes mellitus, acu
psychoses, Cushing's syndrome (or Cushing
disease), overwhelming spreading (systemic) i
fection, or predisposition to thrombophlebitis.

Arthralgen-PR is generally contraindicated
patients with uremia and viral infections, includi
poliomyelitis, vaccinia, ocular herpes simplex, a
fungus infections of the eye. It is also contrain
cated in patients with chicken pox or susceptib
persons exposed to it.

SUPPLY: Arthralgen (white, scored) and Arthr
gen-PR (yellow, scored) tablets are available
bottles of 100 and 500.
*Cohen, et al: J.A.M.A., 165:225, 1957.

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Keeping flies out of pharmaceutical production areas is important, yet entrances must accommodate heavy traffic of people and materials. In fact, at Eli Lilly and Company, the entrances to certain production facilities where traffic is heaviest have no screens or doors. □ This makes it look easy for flies to get in. But let one try it and he is literally picked up by a fast-moving blast of air and thrown for a loss—back outside. This "curtain of air," moving down and out from the top of the open doorway, bars the entrance and keeps flies out . . . still another step demonstrating the care that goes into the finished product.

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EDITORIALS

Mesh, Medlars and Grace

No, these are not the new handwriting on the wall—or, come to think of it, maybe they are. Mesh, Medlars and Grace are portmanteau phrases for new automated equipment to facilitate searching the medical literature. They are described in the April 20, 1964, JAMA by Messrs. Scott Adams and Seymour Taine, both of the National Library of Medicine.

GRACE means Graphic Arts Composing Equipment. MEDLARS is shorthand for Medical Literature Analysis and Retrieval System. MESH means Medical Subject Headings. You start with MESH. This is a list of 5,700 medical terms. Indexers read the titles and summaries of articles and pick out the appropriate MESH headings. Then, through GRACE, these are set on magnetic tape. When the machine is asked for a listing of all articles on a certain subject, the searcher converts the subject into a numerical code. He gets as a first listing all papers indexed under that code. If, as is often the case, the user wants to know about the coexistence of two subjects (as, for instance, rheumatic fever in cardiac children), a second work-sheet lists the code for the second topic; then the machine compares the two lists and spews out the references to articles that are indexed by both numbers.

As a further refinement, MEDLARS can be asked to list only papers written in say, English and French; or all indexed languages except Rumanian. MESH has special numeral codes for articles on certain age groups or for those dealing with experimental animals rather than human subjects. Thus the focus can be sharpened.

This is, one supposes, the wave of the future. At the moment, there seem to be two unfortunate bottlenecks. A human indexer has to read the title and summary to select the right words from MESH. And another human has to find the articles and abstract them. But let us wait. By the end of the century, these two troublesome human beings can be eliminated and we will have MEREWIPE—Medical Research Without People.

Mesh, Medlars and Grace. Mene, mene, tekel upharsin!

Blood

You have less than two gallons of it, flowing through miles of tubes and tubules, bringing food, water, and oxygen to all parts of the body. It carries off waste, redistributes heat, and regulates temperature. It is a shield against infection. You have some 30,000,000,000,000 erythrocytes (3 and 13 zeros) and 50,000,000 white cells. Those red cells don't last long. They are knocked around, bump into other cells, squeeze through narrow passages, contract and expand as the pressure varies—so in four or five months, the red cell gives up and goes to the spleen for a decent burial.

In the literature and minds of the people, blood is associated with both good and bad things—more often with the bad, when one speaks of blood-thirsty, blood-curdling, or blood-shed. But blood is also the magic fluid, often a life-saving alembic. Etymologically, the word is akin to "bless" (consecration in blood); and for a long time in medical history, blood-letting was considered a healing process. Blood has been many other things in our history. To the British today, bloody is a dirty word. Yet the adjective "sanguine" is a hopeful one. Blood is other things. It is thicker than water.

It is the forbidden fruit: "Ye shall eat no manner of blood" (Leviticut 7:26).

It is the seed of a new faith: "The blood of the martyrs is the seed of the Church" (Tertullian).

It is the symbol of guilt ("Will all great Neptune's ocean wash this blood clean from my hands?"—Macbeth, Act II).

It is a badge of kingliness (the blood royal).

It is a measure of love (". . . the cold in blood, their love can scarce deserve the name"—Byron).

Perhaps Goethe said the last word on it—*ein ganz besondrer Saft*—"a juice of rarest quality."

It is the one medication that no commercial pharmaceutical laboratory can make. It is made, instead, in that inimitable and most wonderous laboratory of all: the human body.

Have you made your deposit in your local blood bank? Doctors, of all people, should not need coaxing.

Our Oldest Ally

Nursing is Medicine's oldest ally, and it is essential that we maintain good reciprocal relations with the nursing profession. This, in turn, requires open channels of communication. To this end, the American Medical Association has a Committee on Nursing. It works closely with state medical societies, and particularly with those committees responsible for maintaining liaison with members of state nursing organizations. Prior to developing a definitive program geared to the needs of the states, the committee believed it was essential to ascertain the extent of nursing liaison activities in all of the state societies. To elicit information for this program, the staff prepared a questionnaire which was forwarded to 52 state societies early in 1963. The following is a sampling of the information gleaned from the data:

—Forty-one of our 50 state societies conduct active liaison programs with nursing groups. In 27 of these societies, meetings are called by either nurses or physicians. A committee on nursing, or comparable group, is responsible for liaison with nursing organizations in 35 states.

—Of the subjects most frequently discussed at joint meetings, nursing education, the physician-nurse relationship, patient care, and the shortage of nurses represent concerns of the physician.

—Suggestions for improving the nurse-physician relationship were to improve understanding and communication through joint effort (e.g. jointly planned refresher courses), to establish nurse liaison within the states and to meet frequently with nursing groups.

The findings of the survey would indicate that the committee should concern itself with the following objectives:

1. To devise a means of communicating with state societies in order to keep them informed on nursing problems and trends.
2. To prepare a simple guide to assist those state societies having no liaison activities with nursing groups to develop formal programs and to expand and strengthen present programs of existing committees.
3. To consider national and regional follow-up conferences after the first national conference for physicians and nurses.

It was sad to note that in nine states (some of them rather well populated) there seemed to be no forum at all for the exchange of ideas on the subject.

A fuller report on this survey is available in the May 18, 1964 issue of the JOURNAL of The American Medical Association.

It is probably fair to say that there is no professional group in the healing arts field with whom we need closer liaison and more cooperative working relationships.

The physician's responsibility for furnishing leadership in civil defense and disaster programs is here highlighted by one of the medical pioneers in the field.

Community Emergency Health Services Planning*

Jack R. Karel, M.D./Hillside

President Eisenhower once said that planning is everything, but, when the emergency occurs, plans go out the window. "The definition of 'emergency'," he added, "is that it is unexpected; therefore, it's not going to happen the way you are planning." This paradox may be startling to some of us who have devoted so much of our time and energies to emergency planning. However, the paradox is cogent—for on the one hand, it expresses the virtue and the necessity for undergoing the planning process—not once, but continually; the need to develop—deliberately and without overwhelming pressure—the organization and the habits of thought and action which are essential to effective performance under stress. On the other hand, it expresses the fallacy of becoming wedded to static plans which are sure to become outdated and hampering. An inflexible plan designed to fit one set of conditions could easily prove worse than useless under different conditions.

To treat the subject of Disaster Medicine and Health Protection seriously and realistically, there will have to be drastic and radical changes in our medical thought and practice.

For instance, in the case of medical supplies, it is possible to identify in advance those "item-deficiencies" which can be purchased and stockpiled. In the case of medical and health manpower, the deficiency can be identified—but stockpiling of manpower is impossible. The only alternatives are:

1. The extensive training of large segments of the population in Medical Self-Help to reduce (at least partly) the *requirements* for manpower.

2. Expansion of training programs and dissemination of informational material pre-attack for the development of skills and capabilities of the paramedical personnel, so that they may free the physicians to oversee and contribute to the survival of a *larger* number of patients.

Unless physicians are willing to take interest in teaching the various procedures, they will not be carried out at the proper time to their satisfaction. Wards and out-patient departments, especially of the larger hospitals, offer to the paramedical professions the best opportunity of learning, under supervision, how to handle the acutely ill and injured person.

We should not be so concerned about major plans for having a given individual at a given time at a given place, because this may not be feasible after attack. Instead, let us provide each individual of our medical, health, and paramedical professions with an individual knowledge and understanding of the very unusual conditions under which they will have to work, the unorthodox methods of triage or priority, and the austere technics to which they will have to adapt themselves under the mass environmental casualty situation. The members of the paramedical professions and the medical profession, too, must expand their knowledge and capabilities in the field of epidemiology, environmental health, and other aspects of health protection.

*Presented at the New Jersey Health Mobilization Institute in Newark on February 18, 1964. Dr. Karel is Chairman of the Special Committee on Disaster Medical Care of The Medical Society of New Jersey and Deputy Coordinator of the Union County Civil Defense and Disaster Control.

3. Another method of increasing the potential of each individual physician envisages the survivors emerging from public fallout shelters as consumers of our medical and health resources. The casualties, those with radiation illness, and the threefold increase in the usual diseases will place a heavy demand upon our manpower, our supplies, our facilities. Immediate and skillful post-attack management of all medical and health resources will be essential, because any error in judgment and action occurring in the immediate post-attack period may cost many lives and waste quantities of irreplaceable resources.

We—and especially physicians—hospital administrators, pharmacists, pharmaceutical representatives, and local health officers must be aware of, and understand the need for, resource management and contribute according to our abilities to the pre-attack efforts of planning and training. If we don't, there will be no post-attack local capability, and no proper local resource management.

Having regard to our likely resources, we need to define the principles upon which priorities of medical care and health protection services will be established. Based on these principles of priority, we must develop standardized austere medical procedures for emergencies and ground rules for giving medical direction to paramedical and auxiliary workers in the procedures for the austere care of the sick and injured. Since such decisions establish levels of medical care, they have given rise to controversy.

Our greatest problem has been how, in *peacetime,* to interest the whole medical profession in *wartime* procedure under wartime conditions.

Furthermore, the placing of disaster medicine and health protection services in the hands of non-medical persons is, in part, the result of the medical profession's having let its leadership in community health services decline. This has exposed civil defense medical and health programs to the whims and horse-trading of political manipulation. We should discourage the dispersal of health responsibilities in other services and, in particular, the radiologic services. We should encourage their concentration in the disaster medicine and health protection services under the direction of qualified, trained, and interested physicians.

The emergency medical and health preparedness plan should utilize and build on existing health organizations, services, and professional personnel. There should be an intensification of our peacetime programs, such as the current joint mass poliomyelitis vaccination program. It not only will improve the health and immunity status of our populace; but in addition, it will develop in the communities a sense of readiness and core of skills that are indispensable in a disaster situation. More of such community health efforts under the joint supervision and direction of the medical and health professions should be used as training grounds for civil defense operations.

Disaster Medicine is the health, immunologic and psychologic preparation of large groups of people to meet sudden changes in their environment; and the practical preparation of the medical and paramedical professions to help them meet such circumstances with knowledge, foresight, preparation, organization, discipline, and dignity.

Therefore, disaster medicine should have just as great a significance—to you and me—as does civilian private medicine. As physicians, you have the professional responsibility to keep abreast of the medical and health implications of modern warfare and the equally important obligation to accept responsibility in projecting these implications into policy guidance for the governmental agencies charged with the duty of developing a medical and health preparedness plan for our state and our communities.

I would like to thank Dr. Marie A. Sena, Coordinator, New Jersey State Civil Defense Medical and Health Services, for her assistance in the preparation of this report.

115 North Avenue

Nutrition Conference

New York's Hotel Americana will be the site of the next scientific program of the American College of Nutrition. The session will be on Sunday, October 25. For more details, write to Dr. Robert Peterman, 3 Craig Court, Totowa Boro, New Jersey 07512.

The practitioner is becoming more concerned with clinical investigations of drugs. The magic words "double-blind" and "controlled trial" require thought. A preliminary knowledge of statistical arithmetic is welcome. Some mechanisms of drug studies are described and a check-list for evaluating the resulting clinical report is offered.

The Current Clinical Drug Study*

Alvin C. True, M.D./Deal

The last decade has seen the practitioner become a physician-investigator, responsible for, and increasingly involved in, the clinical evaluation of both new and older drugs. This welcome trend has developed, in a large part, under the aegis of the pharmaceutical industry responding to the promise of greater numbers of potential compounds available for evaluation, the development of whole new areas of drug application (as in psychotherapeutic agents), and the emergence of increasingly refined technology for new drug development and evaluation. This area, however, has been modified as the Kefauver-Harris Amendments of 1962 to the Federal Food, Drug and Cosmetic Act have become effective.[7] Certain points relating to this federal regulation of the clinical study will be touched on.

The Physician-Investigator

Particulars of training, experience, present affiliation, and access to laboratory and clinical facilities all figure prominently in the investigator's standing. One point is of special interest: the physician's attention to the trial. If care and thought are reflected in the experimental design, procedures, observations, and ultimate analysis, a report of the highest significance and interest is most likely to emerge.

For the doctor who has retained some of the scientific bent and natural curiosity of medical school days, be he in solo practice, in a university teaching center, in full time research, or in a clinical specialty, the initiation of a clinical investigation of a drug should be an exciting and absorbing event. He has necessarily considered the many questions related to his study, including his own bias. (Interestingly, in this connection, Greiner[2] has reported an analysis of inherent bias among clinical pharmacologists.) He has usually been approached by a pharmaceutical research unit and has considered what types of assistance and support would be essential for the study. He has appraised his own resources and limitations[6] and made suitable changes in his schedule and commitments so as to allow time, energy, and enthusiasm for the investigation. As the study progresses, he is alert to the necessity for change in experimental design, if indicated, and is watchful for trends in results, variations in dosage requirements, presence of unexpected bi-effects, and other fine points that the competent medical observer is compelled to monitor. Obviously, at the conclusion, much effort goes into analysis of results and preparation of a report, the success of which depends largely on initial planning. Great personal satisfaction may be derived from a careful drug study conducted with good control resulting in acceptable statistical significance and reflecting clinical validity.

*From the Medical Department, Wallace Laboratories, Cranbury, New Jersey.

The Drug

A doctor may be called upon to investigate one of two broad classes of drugs: one with or without an effective New Drug Application. This is essentially permission to make the drug available on a general prescription basis. A drug without an effective N.D.A.† is a "new" or "investigational" drug. If the drug has an effective N.D.A.,† it is most likely a marketed drug, available, and currently in use. This discussion might be said to hinge on *marketed* drugs. As soon as the Kefauver-Harris Amendments became law, the federal regulations concerned with drugs evaluation and surveillance were modified; all presently marketed drugs with an effective N.D.A.† became subject to review, both for the traditional aspects of safety, as well as for efficacy. It is for this reason that clinical evaluations of marketed medications have received increased attention in 1963.

The investigator may expect to receive the material from the pharmaceutical company prepared in a manner dictated by his experimental design. These details relating to the drug are necessary to have at hand before the trial is initiated:

1. Form of medication: tablet, capsule, liquid, and so on.
2. Exact description of the formulation to be evaluated. (Some confusion arises from time to time as to various strengths of one compound or various combinations—several of which may be available.)
3. Full information about the medication as may be contained in a package brochure of instructions, or in the available pertinent literature, or in special data sent by the manufacturer.
4. Presence or absence of control or comparative medications, or placebo, with full information on each.
5. Packaging information, as for example, the number of tablets per bottle, the number of bottles per patient, labeling details, and the like.
6. Arrangements made to refer to the identity of a given package of medication if necessary.

Items 1 through 5 constitute seemingly trivial, yet essential, details relating to the mechanics of the clinical drug study. Item 6 is a convenient safety measure. Perhaps the best device in this respect is a sealed envelope containing the medication code in the hands of the institution pharmacist and/or investigator. This code is opened at the conclusion of the trial unless an unforeseen contingency develops.

† N.D.A. is the form: New Drug Application.

The Dosage

Comparison of two groups of patients receiving disproportionate amounts of test medication is scientifically unsound. Efforts should be made to standardize dosage in the comparative groups. In the absence of a uniform dose for all patients, definite limits in the experimental design should be set, starting with a given initial amount, leveling ideally at an "average" dosage, and not exceeding a maximum total per day. While the need for this parameter is apparent in comparing active medications, the necessity of a prescribed schedule for placebo tablets might be questioned. This may be answered intuitively if we accept the proposition that, for example, 4 placebo tablets per day may be more convincing to the patient in producing a given response than 2 per day. Such is particularly true in studies involving analgesic or psychotherapeutic agents.

The Patient

Selection of the proper patient population is a crucial part of the experimental design. In a sense, there is no such person as an unselected patient. All patients are "selected." Even the procedure of including *every* patient seen in a large general practice results in a population, the members of which have been selected geographically, as clinic or private patient or as attracted to the given institution or physician. If further selection of patients for the study is made on the basis of age, diagnosis, severity of disease, and the like, the investigator must predict what bias this may exhibit in the final outcome.

Factors which limit therapy of the disorder under study, or presence of coincidental disorders, should be considered in forming the experimental design. Thus, a severe cardiac might be excluded from a trial involving treatment of obesity.

Finally to be considered is the problem of informing the patient about his participation in a clinical drug study and even obtaining his

consent. This is basically the physician-investigator's decision. Among the apparent details to be considered are the drug in question, the disease being treated, and the benefit that the patient may derive from the additional individual study he will receive on becoming part of a drug trial. Double-blind studies are consistent with, and even essential to, modern drug evaluation in a clinical setting.

The Experimental Design

"Single-blind study" denotes that the physician is aware of the nature of the medication given to each individual patient, while the patient is not. Ordinary practice is single-blind, in that most times the patient is not informed as to exactly what he is taking. In experimental work, in a single-blind study, some attempt is made to "control" the trial through, perhaps, comparison to other drugs or objective measurements.

"Double-blind investigation" denotes that the patient and the physician are unaware of the medication given to an individual patient. The presence of an identically appearing control drug (placebo or active medication) is required. The investigator is aware of the drug choices in the trial in general so that indications, side effects, and results may be recorded intelligibly.

"Controlled study" states that some comparative agent (placebo or active) is being administered so that relative conclusions may be drawn. This implies the existence of prescribed limitations in the experiment in order to decrease the number of variables bearing on the end result. In seeking to control the clinical drug study, the physician-investigator is invoking the cardinal principles of scientific investigation—definition, isolation, reproducibility, and so on. All aspects of this endeavor are connoted by the general term "controlled study."

"Comparative study" (parallel design) involves the relative evaluation of two or more similar groups receiving different treatments. In contrast, a *"cross-over study"* means one group of patients treated with Drug A, then B and then C. The latter type is dependent upon a rather stable clinical course (e.g., chronic arthritis) so that a relatively constant pathology in the same patient is available for the evaluation of drug responses A, B, and C. A *comparative study* is particularly useful when investigating the effect of a drug in an acute illness, which won't "hold still" for a cross-over. The principal advantage of the comparative type lies in the absence of the contaminating influence of previous drug effect. Although larger numbers of patients are required, if the treatment groups are similar, a sharper clinical impression and a more direct statistical analysis result. The *cross-over,* on the other hand, can use fewer patients because each receives all the medications in the study.

The time-honored method whereby a doctor reports results obtained with known treatment of a number of patients has received the term *"performance study"* or *"case history method."* While it is doubtlessly true that considerable bias may be present, still this type of direct observation yields unique data.

Coding of Drugs

Finally, a word about *coding* of medications. If a double-blind method is to be used, it is necessary for a third party (neither patient nor physician) to prepare the medications. Two basic approaches are available: simple and random. If we were to study the effect of aspirin compared to placebo in the management of headache, a simple coding might be labeling all aspirin bottles "1" and all placebo bottles "2." In random coding, if 50 patients were to be studied, each would be assigned a number 1-50. Thus, numbers 1, 2, 7, 8, 10 might be aspirin and 3, 4, 5, 6, 9 would be placebo, and so on. The coding would be balanced so that 25 of the randomly assigned numbers would be labeled with an aspirin code number and 25 with a placebo code number.

In the simple coding method, the research and nursing personnel may form opinions as to the code identity. This is undesirable. It introduces considerable bias into the trial, whether their judgment is wrong or right. The effectiveness of a placebo may be quite pronounced, particularly when evaluated by a subjective response.

Response Specificity

The best procedure to follow in ascertaining the efficacy of any test medication is to insist

that the responses sought for in the trial be as specific and critical as possible. Thus, if a patient's anxiety state is to be recorded, in addition, we might question related symptoms such as insomnia, irritability, and apprehension.

Test medications will include the preparation under study and one for comparison. All should be identical in appearance and, if possible, in taste. An inert material may be prepared as a suitable placebo by addition of a small amount of bitter, therapeutically inactive flavoring. Active materials, when used as a comparison drug, are best administered in their known recommended dosage; for example, if a standard preparation, usually in 50 mg. tablet form, is prepared for the trial in 62.5 mg., valuable direct comparisons to prior work may be lost.

In conducting the trial, it should be anticipated that within the first few weeks small practical difficulties may present themselves. Therefore, allowances should be made to incorporate suitable improvements in the study plan without undue loss of time or jeopardizing the entire investigation.

Concomitant Therapy

The use of other medications or treatments in a clinical trial increases the number of variables. In the ideal trial, the patient receives only the drug specified in the experimental design. Frequently, however, the problem arises that additional medications (e.g. digitalis), sufficiently distant in action and use from the compound under study, are required for the patient's well-being. If these are given in such a manner as to fall into a uniform distribution within the format of the study, their administration may be accepted.

Another problem arises when the study is constructed to inquire into the action of Compound X given in company with similarly acting medications. This type of datum is helpful in predicting the utility of Compound X in a general medical practice or in the treatment of patients with multisystem disease. Here the experimental design may be very complex and the conclusions must be drawn with caution.

Report Form

The report form is a fascinating and essential part of the research plan. As soon as the medical observer departs from a simple narrative description, some outline or report form is necessary. It is tempting to make it very elaborate and encompass a large amount of data—a temptation which is imperative to resist. A complex form does not get completed even by the most meticulous observers. Furthermore, it may gather data which is confounding rather than contributory; and, most important, the salient parameters of the drug evaluation may be lost in a mountain of symptoms, degrees of severity, and informal comments. One could not presume to display an ideal form. The following suggestions as to contents, however, should be helpful:

1. Patient identification by number (not name or initials), age, sex, and so on.
2. Concise description of history, physical status, and diagnosis.
3. Progress report, including dosage, initial symptomatology, and subsequent course.
4. Room to record side effects, comments, and concomitant therapy, if applicable.
5. Suitable scale to summarize improvement or other results by degree.
6. Employment of a check mark system to save time and standardize data (e.g., ( ) IMPROVEMENT ( ) NO CHANGE ( ) NO IMPROVEMENT).
7. A statement indicating whether the medication was taken.
8. Identification of the investigator and date.

Statistical Analysis

As Mainland[4] has observed, there has been a welcome increase in the "statistical attitude" toward medical investigations. More recently, however, he[5] pointed out that "sometimes 'significance' tests are not only unnecessary but inappropriate." Part of the reason for the inaccuracy in applying statistical methods to clinical trials lies in unfamiliarity of the medical investigator with available procedures. Since the appropriate analytical device should be anticipated in the experimental design, possibly a knowledge of the statistical arithmetic may be helpful in alleviating existing confusion.

Essentially, the various statistical technics are aimed at finding out whether differences in

results are meaningful or whether they could be chance differences. It is impossible to present in this small space even an elementary summary of the chi square technic, the calculation of probable error, the computation of indices of correlations, and so on.[1,3] Any physician willing to spend some time and effort on it can learn how to handle these manipulations which are really not as complicated as they seem. Anyone who can earn an M.D. degree can learn them. Here is a list of few accessible books on the subject which will repay study:

Franzblau, Abraham. A Primer of Statistics for Non-statisticians. New York, Harcourt-Brace.

Hill, A. Bradford. Principles of Medical Statistics. New York, Oxford University Press.

Holman, Leonard. Simplified Statistics. London, Pitman.

Mainland, Donald. Elementary Medical Statistics. Philadelphia, Saunders.

Moroney, M. J. Facts from Figures. Baltimore, Penguin Books.

Wallis, W. A. and Roberts, H. V. Statistics: A New Approach. Glencoe, Illinois, The Free Press.

Zeisel, Hans. Say It With Figures. New York, Harpers.

Comment

In these days of increasing drug development activity, the physician who is treating patients must be aware of drug investigations, and particularly if he anticipates the continuing development of new drugs for these patients; then he must, from time to time, participate in the accumulation of pertinent data. Of course, while this process is in daily operation through personal communication, symposia, and medical meetings, the place of the documented clinical study is becoming increasingly prominent. This discussion is concluded with a listing of pertinent items necessary in planning the current clinical investigation and in preparing (or reading) the resulting paper.

Key Elements of a Clinical Study Report

1. Statement of the investigation.
2. Reason for conducting the investigation (hypothesis and results anticipated).
3. Background statements.
4. Location.
5. Special facilities (if any).
6. Previous experience with the drug in question.
7. Patients: age; sex; distribution in each group, diagnosis and additional pertinent information.
8. Materials:
   (a) Name of drug.
   (b) Milligrams per dose (and type of preparation).
   (c) Accompanying placebo, if any.
   (d) Statement of whether material is marketed or not.
   (e) Minimum and maximum dosage.
9. Methods:
   (a) Limits of the trial (e.g., double-blind).
   (b) Selection of patients.
   (c) Selection of materials.
   (d) Duration of treatment.
   (e) Frequency of observation by the investigator.
   (f) Concomitant therapy (if any):
      1. Drug.
      2. Physical.
      3. Psychological.
   (g) Objective tests.
10. Results:
   (a) Report forms.
   (b) Criteria.
   (c) Validity of observations.
   (d) Consideration of special parameters.
   (e) Side effects (volunteered or elicited).
11. Tabulation. (Appropriateness of related groups being tabulated and compared or contrasted.)
12. Statistical analysis planned.
13. Statistical analysis performed.
14. Conclusions:
   (a) Correlation with the statistics.
   (b) Summarizing important points.
   (c) Relating results to past work or anticipating future investigations.
15. References.

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[2]Greiner, T.: Subjective Bias of the Clinical Pharmacologist, JAMA 181:120-121 (July 14) 1962.

[3]Herdan, G.: *Statistics of Therapeutic Trials,* London: Elsevier Publishing Company, 1955, p. 43.

[4]Mainland, D.: The Clinical Trial—Some Difficulties and Suggestions, J Chronic Dis 11:484-496 (May) 1960.

[5]Mainland, D.: Commentary, The Significance of "Non-significance," Clin Pharmacol Ther 4:580-586 (Sept-Oct) 1963.

[6]Schneiderman, M. A.: Controlled Clinical Trials; Monday's Count-down for Tuesday's Launching, J New Drugs 1:250-255 (Nov-Dec) 1961.

[7]Title 21—Food and Drugs, Part 1—Regulations for the Enforcement of the Federal Food, Drug and Cosmetic Act, Federal Register (Part II) 28:6375-6387 (June 20) 1963.

83 Neptune Avenue.

Are you making full use of the Rehabilitation Counselor? He can be a powerful associate in helping a chronically ill patient return to gainful employment.

Eliminating Vocational Barriers Through The Physician-Rehabilitation Counselor Team

Herbert Rusalem, Ed. D. and Richard Acciavatti, D. Ed./So. Orange*

Subsequent to illness, despite the best medical care, some patients cannot return to their regular employment. Common examples include the manual worker who has had a serious heart attack, the postman who has peripheral vascular disease, the bookkeeper who has suffered a visual loss, or the engraver who has developed arthritis in his hands. Multiply these examples by the hundreds and add to them the limitless variety of interests and capacities of people and you have some concept of the range of vocational problems that appear in any physician's case load. In only a few situations does the doctor decide that there can be no return to any form of employment. Such cases are becoming less frequent as physicians recognize the therapeutic value of work and the desirability of selectively placing the individual on a job consistent with his limitations. The modern physician rarely stops at the treatment of disease. He is concerned with the social and psychologic recovery of his patient. One of the evidences of this is the patient's resumption of remunerative employment.

Self-respect in our society often depends upon being able to earn a living. Work fills empty hours that might otherwise be unbearable, and employment helps to ease some of the financial burdens that accompany long-term illness. As a result, physicians show interest in the patient's occupation and his prospects for employment. Often, a guideline provided to the patient by his physician results in a return to work and an avoidance of a lifetime of dependency. Such common-sense advice is exceedingly valuable.

Just as a lay person may give superficial first aid before the doctor arrives, so the physician may give some vocational first aid before the rehabilitation counselor arrives. And, indeed, first aid may be all that is required in some situations. More commonly, however, long-term or chronic illness seriously disrupts the patient's career and causes severe social psychologic damage. When this occurs, a vocational specialist is needed.

The rehabilitation counselor is a professional worker who spends two years of graduate study in learning his field. He learns about the dynamics of human behavior, vocational and psychologic testing, the medical aspects of disability (invariably taught by a physician), counseling technics, the principles and practices of vocational rehabilitation, placement and employment problems, and the psychologic aspects of physical, mental, and emotional disabilities. As part of his total program, the rehabilitation counselor spends a year in intern-

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ship, during which he practices his profession under the supervision of qualified counselors in rehabilitation centers, state rehabilitation agencies, hospitals, and community counseling services. After he receives his master's degree, the rehabilitation counselor enters into the practice of his profession, almost always in teamwork with the physician. There are currently 35 graduate programs in Rehabilitation Counseling in the United States. The only program of this type in New Jersey is at Seton Hall University at which some 40 graduate students are currently preparing for careers in this field.

The rehabilitation counselor has a fairly clear-cut function. In cooperation with the physician and other members of the team, he assists the patient to re-evaluate his capacities, to select a new career (if the old one is medically and psychologically unfeasible), to plan means of preparing for the new career, to train for it, and to find employment that is medically and vocationally suitable. In essence, the rehabilitation counselor is the vocational specialist on the team. However, without the help of the physician, it would be impossible to do rehabilitation counseling.

Most of the disabled persons served by the rehabilitation counselor are referred directly or indirectly by the physician. The counselor does not enter the picture until the doctor decides at some point that it would be desirable for vocational planning to begin. Although some physicians wait too long to make such a referral, most doctors know that the earliest possible referral is best for the patient in that it gives him hope, builds his morale, and offers him something besides his illness to think about. Early referral to the rehabilitation counselor reduces the period of idleness for the patient after medical discharge. Thus, if counseling begins early, the patient may be far enough advanced in his vocational planning by the time of discharge to embark immediately upon a vocational program. The physician has a key role in the process through being aware of the need for early referral and for encouraging the patient to accept such a referral even though some phase of medical treatment may still be in progress.

The rehabilitation counselor depends upon the physician for medical information about the patient. Since the vocational rehabilitation plan has to conform to the medical realities, the doctor must communicate the pertinent medical facts to the counselor if the latter is to perform effectively. These realities not only include the medical history, the diagnosis, the treatment, the prognosis, and the recommendations for continued medical care. They should also spell out the functional limitations in the case. The counselor needs to know the work tolerance of the patient, his capacities for walking, standing, running, climbing, and lifting, and the types of working environments which should be avoided. As the physician and the rehabilitation counselor work together, they develop a reciprocal understanding of the types of information needed in various types of cases. For instance, in epilepsy, the counselor, in addition to needing the data noted above, should be made aware of the type of medication being taken, its effect upon the alertness of the individual, the character and frequency of the seizures, and the nature of the aura, if any.

As the rehabilitation counselor and the patient enter the vocational diagnosis phase, a number of technics may be used in the process including psychologic tests, work tests, job tryouts, counseling interviews, and occupational therapy evaluations. When the counselor and the patient have arrived at a vocational diagnosis, counseling is offered around possible occupations for the patient. When a decision is reached, the rehabilitation counselor commonly confers with the physician to verify the choice and to make certain that it is consistent with the medical picture.

After medical confirmation has been obtained, the counselor assists the patient to find training facilities that will prepare him for the selected occupation. These may include schools, colleges, trade institutes, apprenticeship training, on-the-job training, tutoring, and adjustment training. In each instance, the rehabilitation counselor is concerned both with the quality of the training and with the physical and emotional climate in which it will occur. If the training resource seems satisfactory, the counselor will induct the client into the situation,

assisting him to make the fullest possible use of the instruction he receives. From time to time, the patient may reveal symptoms which, if untreated, may retard his training progress. As a result, the counselor makes periodic reports to the physician, keeping him informed about the patient's apparent condition and asking for his assistance when additional medical intervention seems to be indicated.

After the patient completes his training, the rehabilitation counselor, working with other placement resources in the community, seeks out a selective placement that will be suitable for the individual. Before doing so, however, he may want to consult with the physician so that between them they can decide upon the work situations which should be avoided because of their possible unfavorable influence upon the patient's health. When these limitations have been spelled out, the placement wheels are put in motion and, hopefully, the client soon enters employment.

The cooperation between the rehabilitation counselor and the physician does not end here. During the first few months of the patient's employment, the counselor occasionally re-evaluates the situation in routine followups. If his check on the patient reveals physical problems which may interfere with employment success, the counselor consults with the physician and, if necessary, suggests re-examination and possible additional medical treatment. After the patient has functioned successfully on the job for a period of time, the rehabilitation counselor bows out of the picture, re-entering it only if the physician and/or the patient requests him to do so.

If a physician feels that a patient would benefit from rehabilitation counseling, he may refer him to a counselor in a rehabilitation center, a sheltered workshop, a community counseling agency, or a hospital. Most commonly, however, in New Jersey, the referral is to the New Jersey Rehabilitation Commission in Trenton.† The Commission has local offices throughout the State from which rehabilitation counselors bring service into the patient's own community. The New Jersey Rehabilitation Commission, supported by State and Federal Funds, employs rehabilitation counselors who are trained to work cooperatively with physicians on behalf of disabled persons. In referring a patient to the Commission, a physician may have full confidence in the quality of service and the understanding which his patient will receive.

As the one University which provides training in rehabilitation counseling in New Jersey, Seton Hall is prepared to give general advice to physicians and their patients regarding resources. Although the University provides no direct service to patients, the Rehabilitation Counselor Education staff can provide information on New Jersey's Rehabilitation facilities to physicians and patients.

Summary

A close relationship between the physician and the rehabilitation counselor is essential to the welfare of the patient who it fit to return to some form of employment. Fortunately, these two professions work very closely together. Obviously, the rehabilitation counselor is unqualified to practice medicine, and the physician usually lacks the special training to do vocational guidance. Together, however, they form a powerful team, the combined strength of which reduces the deleterious effects of serious illness and disability. Working together, with the patient as a third member of team and drawing upon other disciplines, as necessary, the physician and the rehabilitation counselor represent one of the best examples of interdisciplinary teamwork.

The authors are grateful to Mrs. Beatrice Holderman, Director of the New Jersey Rehabilitation Commission, and her staff for their invaluable assistance in preparing this paper.

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Seton Hall University

A screening survey of 20,000 employees shows a "pathology" rate of some 13 to 20 per cent, with obesity and hypertension the prime culprits.

Comparison of Three Health Test Survey Programs

George P. Bisgeier,* M.D./Newark

In an effort to provide medical services to all employees, the New Jersey Bell Telephone Company adopted a health screening procedure in 1951 and repeated it in 1955 and 1960. Tests included a 70 millimeter chest x-ray, urinalysis for sugar and albumen, and determination of height, weight, and blood pressure. Mobile units consisting of a fixed x-ray installation and a technician accompanied by two nurses and a clerk visited 160 locations in each survey. Any employee who had a significant abnormality was then examined in our Medical Department. If needed and possible, further tests were done until a final diagnosis was reached.

Multiple screening has been the subject of considerable controversy. It has been indicted by some as an incomplete examination leading to a false sense of security. An industry such as an operating Telephone Company presents great problems in accomplishing complete examinations. Our 23,000 employees are in 375 locations throughout the state. We have found that our voluntary periodic health evaluation program is utilized chiefly by individuals within the immediate area of our Medical Department. By bringing the medical unit to the work location, we were able to screen large numbers of employees.

There are limitations to this type of examination, and we did what we could to minimize them. All abnormalities detected were investigated by our Medical Department. Only after an examination and discussion with one of our examining physicians was an employee told of a medical condition. Then, he was referred to his personal physician for care. This led to a much higher number of employees actually consulting their personal physicians.

We stressed (in all our publicity releases and discussion of the program) that these examinations did *not* replace a complete physical examination. Finally, we were satisfied by our earlier experience that these examinations provided a worthwhile function in the production of "health consciousness" among our employees as well as detecting certain medical abnormalities previously unknown to the employee.

Results

Participation in these surveys was as follows:

1951	17,892	(79.5%)
1955	21,029	(85 %)
1960	20,880	(83.5%)

As shown in Table I, in 1960 our ratio of

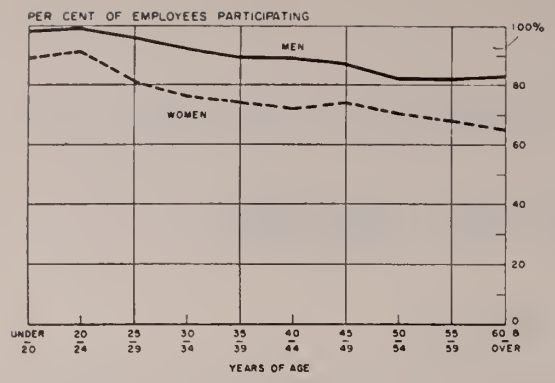
Table I

HEALTH SURVEY—1960

PARTICIPATION OF ELIGIBLE EMPLOYEES

AGE BAND	MEN		WOMEN	
	NUMBER ELIGIBLE	PER CENT PARTIC.	NUMBER ELIGIBLE	PER CENT PARTIC.
UNDER 20	53	98%	1,753	89%
20 — 24	742	99	2,890	91
25 — 29	2,121	96	1,559	81
30 — 34	1,954	92	1,713	76
35 — 39	1,692	89	1,470	74
40 — 44	1,064	89	1,052	72
45 — 49	489	87	1,385	74
50 — 54	839	82	1,700	70
55 — 59	859	82	852	68
60 & OVER	456	83	345	65
TOTAL	10,269	90%	14,719	79%

* Dr. Bisgeier is medical director of the New Jersey Bell Telephone Company.



participation dropped with increasing age. The decrease was most noticeable in the female where from a peak of 91 per cent participation in the 20 to 24 age group it fell to 82 per cent in the 50 to 59 year age bracket. This poses a problem, since we would expect to find more pathology in older people. Table 2 dramatically reflects the incidence of abnormalities found in men and women. For men (in the 1960 Health Survey) the incidence of pathology increased directly with age from 2 per cent in the "under age 20 age band" to 21 per cent in the "60 and over" bracket. For women, the incidence of pathology holds fairly stable at about 2 per cent for the group below the age of 45. Following age 45, the incidence of pathology rises with age until a maximum of 16 per cent in the 60 and over age group.

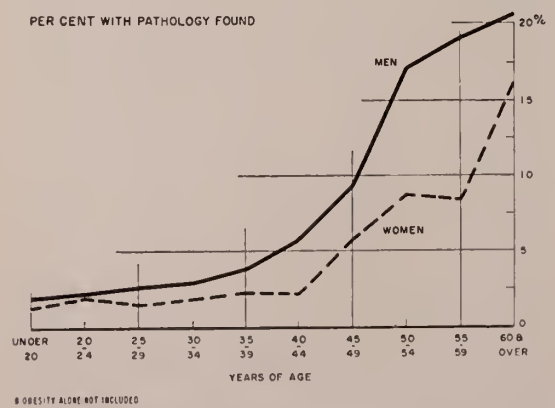
Table II

HEALTH SURVEY – 1960

PATHOLOGY FOUND* – BY AGE AND SEX

PER CENT OF TOTAL GROUP SCREENED (20,880)

AGE BAND	MEN		WOMEN	
	NUMBER PARTIC.	% WITH PATHOLOGY	NUMBER PARTIC.	% WITH PATHOLOGY
UNDER 20	52	1.9%	1,553	1.4%
20 — 24	734	2.3	2,631	2.0
25 — 29	2,026	2.6	1,263	1.4
30 — 34	1,788	2.9	1,303	1.9
35 — 39	1,513	3.8	1,092	2.3
40 — 44	950	5.7	759	2.2
45 — 49	424	9.4	1,018	5.8
50 — 54	690	17.2	1,197	8.8
55 — 59	708	19.2	579	8.5
60 & OVER	376	20.5	224	16.1
TOTAL	9,261	6.6%	11,619	3.5%



* OBESITY ALONE NOT INCLUDED

A previous report† presented comparative results of the 1951 and 1955 surveys. Tables 3 and 4 show the major pathology found in all three surveys as well as the number of individuals referred to their personal physician for treatment or for more definitive diagnosis. Since some controlled cases of diabetes and hypertension would not be detected by our screening methods, the incidence figures for these will not be exact.

Table III

HEALTH SURVEYS

1951, 1955 & 1960

PREVALENCE OF CERTAIN CONDITIONS IN TOTAL GROUP SCREENED

CONDITION	NO. OF CASES			% OF EMPLOYEES		
	1951	1955	1960	1951	1955	1960
OVERWEIGHT (20% & OVER)	1,525	1,866	1,713	8.50%	8.87%	8.69%
HYPERTENSION	1,474	1,081	663	8.20	5.14	3.17
DIABETES MELLITUS	56	35	42	.31	.17	.20
ACTIVE TUBERCULOSIS	8	2	0	.04	.01	0
CANCER OF THE LUNG	0	1	6	0	—	.03

Of those employees who participated in both the 1955 and 1960 Surveys, approximately 1/3 of the men and 1/4 of the women were in the "satisfactory" classification in both. Only one per cent of the group were able to correct major

† Postgraduate Medicine, 24:658, December 1958.

Table IV

HEALTH SURVEYS
1951, 1955 & 1960
NUMBER OF CASES REFERRED TO PRIVATE PHYSICIAN

CONDITION	1951	1955	1960
A. HYPERTENSION	180	432	515
B. DIABETES	45	24	26
C. KIDNEY CONDITION			
CHRONIC NEPHRITIS	—	1	—
SIMPLE ALBUMINURIA	—	12	43
TOTAL	—	13	43
D. PULMONARY			
ACTIVE TUBERCULOSIS	8	2	—
ARRESTED TUBERCULOSIS	25	5	15
PULMONARY FIBROSIS	9	6	4
LUNG CANCER	—	1	6
BENIGN PULMONARY TUMOR	2	1	3
BRONCHIECTASIS	—	—	1
TOTAL	44	15	29
E. THICKENED PLEURA	3	2	1
F. EVENTRATION OR ELEV. OF DIAPHRAGM	1	1	2
G. BONY STRUCTURES			
SCOLIOSIS	—	—	2
BONY ANOMALY	—	—	2
TOTAL	—	—	4
H. CARDIOVASCULAR			
ENLARGED HEART	5	6	20
WIDENED AORTA	2	1	5
TOTAL	7	7	25
I. MISCELLANEOUS			
HISTOPLASMOSIS	—	—	2
HODGKIN'S DISEASE	—	—	1
INTERCOSTAL CALCIFICATION	—	—	1
SARCOIDOSIS	—	1	2
TOTAL	—	1	6
GRAND TOTAL	280	495	651[R]
PER CENT OF TOTAL PARTICIPANTS	1.6 %	2.4%	3.1%

R OF THESE 651 CASES, 70 ALSO HAD A 20% OVERWEIGHT CONDITION, COMPARABLE FIGURES FOR 1951 AND 1955 ARE NOT AVAILABLE.

pathology found in 1955 sufficiently to become satisfactory in 1960. Five per cent of the men and three per cent of the women moved in the opposite direction, from either completely satisfactory or having minor deviations to major pathology. These figures represent all types of pathology; and, of course, some abnormalities are permanent although under control; e.g., arrested tuberculosis.

Table V

HEALTH SURVEYS
RELATIONSHIP OF WEIGHT TO THE INCIDENCE OF CERTAIN ABNORMALTIES

PERCENTAGE OF EMPLOYEES WITH:	1951		1955		1960	
	NORMAL WT.	20% OV. WT.	NORMAL WT.	20% OV. WT.	NORMAL WT.	20% OV. WT.
HYPERTENSION	5.8	21.1	4.5	8.8	1.8	11.2
ENLARGED HEART	.6	1.5	.3	3.3	.1	1.0
HYPERTENSION AND ENLARGED HEART	.1	1.7	.0	.9	.0	.5
DIABETES MELLITUS	.3	.6	.1	.6	.2	.6
ANY PATHOLOGY	—	—	—	—	3.2	13.0

Our findings confirm other studies showing that the incidence of hypertension and diabetes increases with obesity. These findings are table 5. This exhibit also shows that in 1960 all pathology was increased in overweight employees.

The Non-participants

Every screening survey (like every public opinion poll) is haunted by the distorting effects of the non-participants. What about employees who were on our payroll in 1960, but who did not participate? There were 4171 of them. Were they simply without "health consciousness"? Or, on the contrary, were they people who knew that they had something wrong and did not wish it to be on our Company records? Were these individuals who had been identified in previous health surveys and did not wish to go through further medical examinations? A list of the 4171 employees who were on the payroll but did not participate in the 1960 survey was prepared. Ten per cent of them were chosen by random selection, and the medical records of the 417 were reviewed with the following results:

No pathology	333
Hypertension	16
Obesity	11
Hypertension and obesity	8
Hypertension and diabetes	3
Arrested tuberculosis	3
Miscellaneous x-ray abnormalities	4
Other miscellaneous abnormalities	7
False positive on previous survey	7
No medical record	15

The conclusion drawn from this is that basically the people who did not participate in the survey were about as healthy as those who did. We found approximately 20 per cent pathology among all participants. It should be noted that these were medical records which included June 1962, for those employees still on the payroll.

Some employees certainly did not participate in the surveys because they were already aware of a health condition. On this very limited obser-

vation, two years after the survey there are only two cases in the sample in which we could definitely say that the condition would have been detected earlier if the employee had participated in the 1960 Survey. Nevertheless, this represents 20 individuals in the full population and could be of medical import.

Obesity

We have always empirically considered obesity a poor prognostic omen. We therefore decided to check the departmental absence record of a sample of employees who were at least 20 per cent overweight in 1960, and whose weight had either been stationary or had increased since 1955. There were some 1100 in this group. The sample population (10 per cent of this total) lost an average of 8.7 working days due to illness in 1961 giving an absence rate of 3.5 per cent. Our Company average for the year of 1961 was slightly under 3 per cent. This means that approximately 1300 days were lost in 1961 which could have been saved if these people could have maintained an absence record equal to our Company average. During the first 6 months of 1962, our sample population was losing time from work at a rate of 9.2 days per year per individual. These figures lend credence to our contention that obesity is a poor prognostic sign in reference to future attendance.

Subsequent Course

The last analysis reflects changes in our two most common abnormalities in both surveys; that is, hypertension and obesity. How many individuals followed medical advice and effected improvement in either or both of these conditions found in the 1955 surveys? Table 6 tabulates this. To summarize, approximately 13 per cent of the employees normal in 1955 developed either obesity and hypertension, or both, by 1960. Sixty per cent of the 1955 hypertensives improved, but only 30 per cent of the obese employees improved their weight situation; while 13 per cent actually increased in weight. This is also noted in the group with both hypertension and obesity—where a greater ratio could improve or correct hypertension.

Table VI
HEALTH SURVEYS
1960 vs. 1955
(10,917 EMPLOYEES PARTICIPATED IN BOTH SURVEYS)

CONDITION	NO OF EMPLOYEES	PER CENT
NO HYPERTENSION OR OBESITY		
UNCHANGED	6,761	86.6%
DEVELOPED HYPERTENSION	122	2.0
DEVELOPED OBESITY	888	11.0
DEVELOPED OBESITY AND HYPERTENSION	29	.4
TOTAL	7,800	100.0
HYPERTENSION		
UNCHANGED	66	24.0%
IMPROVED	167	60.0
IMPROVED HYPERTENSION— DEVELOPED OBESITY	29	10.0
REMAINED HYPERTENSIVE — DEVELOPED OBESITY	17	6.0
TOTAL	279	100.0
OBESITY		
UNCHANGED	1,297	50.0%
IMPROVED	767	30.0
IMPROVED OBESITY — DEVELOPED HYPERTENSION	21	1.0
REGRESSED (GAINED WEIGHT)	336	13.0
REMAINED OVERWEIGHT— DEVELOPED HYPERTENSION	121	5.0
GAINED WEIGHT — DEVELOPED HYPERTENSION	15	1.0
TOTAL	2,557	100.0
OBESITY AND HYPERTENSION		
UNCHANGED	59	21.1%
IMPROVED — WEIGHT & HYPERTENSION	65	23.0
IMPROVED — WEIGHT - B. P. UNCHANGED	24	9.0
IMPROVED B. P — WEIGHT UNCHANGED	110	39.0
IMPROVED B. P — GAINED WEIGHT	18	6.0
B. P. UNCHANGED— GAINED WEIGHT	5	2.0
TOTAL	281	100.0

Discussion

Our repeated health surveys have been of twofold benefit. Certain individuals having specific medical conditions have been channeled to their personal physician for needed therapy. The other benefit, albeit intangible, has been an increased "health consciousness."

Certain problems remain to be solved. A more effective weight control program is necessary. Some method of encouraging our older employees to take part in the next health survey is indicated, since this high risk group had the least participation. The possibility of limiting the chest x-ray to certain age/sex groups should also be considered.

Summary

Comparative results of several screening type health surveys have been presented, along with follow-up data. The problem of motivating employees with obesity and/or hypertension to seek medical attention has been highlighted. It has also been shown that absence rates appear higher among employees more than 20 per cent overweight.

540 Broad Street

This is the first case ever reported in the American literature where an incarcerated inguinal hernia developed after a perforation of an umbilical hernia.

Spontaneous Umbilical Hernia Perforation and An Incarcerated Inguinal Hernia*

John Wrable, Jr., M.D./Jersey City

Spontaneous perforation of an umbilical hernia (with or without eventration) is a rare occurrence. When it does occur, it presents a serious surgical and medical problem with a high mortality.[1 2 3] In patients with Laennec's cirrhosis and ascites, the reported incidence of umbilical hernia is higher than normal and varies from 4 to as high as 42 per cent.[4 5 6] Associated inguinal hernia are not uncommon.

Our patient represents the 22d reported case in the American literature to have a spontaneous perforation. This is the first case ever reported to develop an incarcerated inguinal hernia postoperatively. Both were treated successfully.

This was the second East Orange Veterans Administration Hospital admission of a 56-year-old man. While urinating on the morning of admission, he noted fluid running from his umbilical hernia. There was no history of trauma or ulceration of this area.

On his first admission, he was found to have Laennec's cirrhosis with ascites and an umbilical hernia. Response to low salt diet, diuretics, and vitamins was fair. On discharge, ascites and hernia persisted. He denied any weight gain, change in size of hernia, increase in girth, jaundice, dark urine, acholic stools, fever, chills, diarrhea, constipation, hematesis, or melena since previous admission.

Perforation occurred 6 hours prior to admission. Drainage consisted of clear yellowish tinged ascitic fluid with an estimated loss of one to two pints.

Physical Examination. The patient looked chronically ill. He was slightly icteric, in no acute distress, alert, and cooperative. Blood pressure was 120/60, pulse 88, respirations 16, temperature 98.6, and weight 135 pounds. Scleral icterus was present. Scattered over the face, neck, and chest were spider angiomata and telangectasia. Palpable breast tissue was present. The abdomen was proturberant, with bulging in the flanks, and a prominent venous pattern. No fluid wave was demonstrable. A 4 by 4 centimeter umbilical hernia with a 2 millimeter central perforation was present Drainage consisted of clear, yellowish tinged, ascitic fluid. Liver and spleen were palpable 7 centimeters below the right and left costal margins, respectively. No tenderness or rebound was elicited, and bowel sounds were normal. Stool was brown and guaiac negative on rectal examination. Palmar erythema and digital clubbing were present. Neurological examination was normal.

Clinical Course. Under local anesthesia a primary umbilical herniorrhaphy was done, repair consisting of excision of the hernia sac and simple linear approximation of the facia with nylon retention sutures.

Postoperatively, he was placed on tetracycline, low salt diet, and diuretic therapy. There was no further evidence of fluid drainage and patient's temperature remained normal.

On the 15th postoperative day, he developed an incarcerated left inguinal hernia. Under spinal anesthesia, a left herniorrhaphy was done without incident.

Postoperatively patient was continued on tetracycline, diuretic and low salt diet, and continued to run an uneventful, afebrile course. Both umbilical and inguinal wounds healed primarily, and sutures were removed at the appropriate times.

Followup visit one month postoperatively revealed two well healed wounds with repairs intact. Status of cirrhosis was essentially unchanged.

Bontecau[7] in 1858 reported the first case of umbilical hernia rupture in the American literature. His patient, who was pregnant, had a large umbilical hernia which perforated, and a partial eventration occurred while bending forward. The eventration was surgically repaired,

*From the Surgical Service of the Veterans Administration Hospital, East Orange. Dr. Wrable is a resident in surgery.

and she survived in spite of postoperative peritonitis. Others† have reported similar cases with and without eventration. Most of the patients who had umbilical hernia complications were cirrhotics with ascites. The remaining cases consisted of one nephrotic, a pregnant woman, and an elderly female with a massive hernia of many years duration.

The predisposing factors in these cases were a congenital defect in the abdominal wall; or a latent defect, which becomes manifest with progressive increase of intra-abdominal pressure. Erosion, ulceration of the hernia, and poor nutrition were additional factors. Relation to size of hernia was not apparent.

The dangers of removing ascitic fluid from the cirrhotic are well known,[18] as are the complications associated with eventration and hernial incarceration. In the reported cases, peritonitis, shock, bleeding esophageal varices, hepatic coma, renal insufficiency, metabolic acidosis, hyponutremia, hyperkalemia, and pulmonary edema were the leading causes singularly or in combination for the high mortality rate.

Elective herniorrhaphy in cirrhotics with ascites has been successful[2] and is recommended when indicated. In the cases with spontaneous perforation with or without eventration, immediate surgical intervention, postoperative prophylactic antibiotics, and adequate medical therapy will reap a greater number of survivors. Surgical intervention accomplishes two important factors: the prevention of further contamination of the peritoneal cavity and stopping the fluid loss in the cirrhotic patient, which may lead to the metabolic complications.

Summary

A case of spontaneous perforation of an umbilical hernia, complicated postoperatively by an incarcerated inguinal hernia, both treated successfully is here reported.

Early surgical intervention, postoperative prophylactic antibiotic, and adequate medical therapy should reduce the mortality rate. Elective repair is recommended when the patient's status warrants it.

†See references 1,2,3,8,9,10,11,12,13,14,15,16,17

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166 Sycamore Road

Mental Health Conference

The AMA's second Mental Health Conference will be held in Chicago on November 5, 6, and 7. For more information, write to Mental Health Department. American Medical Association, 535 North Dearborn Street, Chicago. Illinois 60610.

This brief vignette pictures some of the giants on whose shoulders we stand.

Calling Dr. Hubbard

Two Hundred Years of New Jersey Medicine

Peter Jay Guthorn, M.D./Neptune City

Today, we have Ben Casey and Dr. Kildare: sophisticated medical symbols and advanced scientific tools. In contrast, it is interesting to look back to the medical scene during the early years of our state and to "call for Dr. Hubbard," a Monmouth County physician of the eighteenth century.

Let us start with Dr. Jacobus Hubbard. Jacobus was born at Gravesend, close to present-day Coney Island, across the lower bay from Monmouth County, in 1739. He embarked upon the study of medicine with Dr. William Clark of Freehold, signing an agreement as an apprentice on August 7, 1760. There is, incidentally, no other known record of Dr. Clark. Some of the clauses[1] in the agreement between Dr. Clark and his apprentice are worthy of note. The term of apprenticeship was four years and eight months, during which time Dr. Clark was to teach Hubbard the practice of a doctor and surgeon. In return, Hubbard was to serve his master faithfully and well, "his secrets keep, his lawful command everywhere obey." "He shall do no damage to his said Master, nor see it to be done by others without letting or giving notice to his said Master. He shall not contract matrimony within the said term. At cards, dice, or any other unlawful game, he shall not play, whereby his said Master may have damage. He shall not absent himself day or night from his said Master's service without his leave, nor haunt ale houses, taverns or playhouses." The consideration was 100 pounds, a sizeable sum. At the termination of the period of apprenticeship, Dr. Clark was to give Hubbard "a new set of surgeon's pocket instruments, Solomon's Dispensatory, Quince's Dispensatory and Fuller on Fevers." This type of agreement was common between masters and apprentices in trades and professions.[2]

After completing his training, Dr. Hubbard established practice in Holmdel. He served as a surgeon during the Revolution. He developed a large and successful practice, and fathered six children. The oldest, Jacobus Hubbard, junior, was born in 1766. The year was momentous not only for Jacobus, junior's birth, but also for the Medical Society of New Jersey†, which was founded the same year.

At its founding in 1766, The Medical Society of New Jersey had many problems, the most pressing being the discouraging and discountenancing of quacks and imposters. So the Society insisted that only those regularly initiated into medicine (either at some university or under the direction of some able and recognized master) be allowed to practice. There were also early resolutions concerning credit, notably that "long credit is an injury to both

*Read at the Monmouth County Medical Society meeting, December 18, 1963.

†It was not then, and never has been, the State Medical Society. In 1766, New Jersey was a colony, not a state. The Medical Society of New Jersey is older than the State of New Jersey, so the noun "State" does not appear in our title.—*Editor.*

[1]Wickes, Stephen: *History of Medicine in New Jersey and of Its Medical Men.* Newark, N. J. 1879, p. 100.

[2]Parish, Darcel, jr.; Sherman, C. A.; Kelby, R. H.; *Collections of the New York Historical Society for the Year 1909.* New York, 1910. pp. 113, 129.

the practicioner and the patient" and that "the cure of all foul diseases should be paid for immediately." Fees were established by the Society, for example:

"Visiting in towns whereby physician and surgeon can readily attend the patient without riding is charged for according to the duration of the ailment and the degree of attendance. In slight cases whereby a visitor too may be wanted—5 shillings; drawing off the urine by catheter, each time, 7 shillings sixpence; consultations, exclusive of traveling fees, 15 shillings; extracting the cataract, 3 pounds; amputation of the breast, 3 pounds; Bubonocele, epiplocele and hernia femoralis, each 3 pounds; castration, each testicle, 3 pounds; fistula in ano, 3 pounds; simple fracture of the thigh or leg bones, 2 pounds."

As a result of the efforts of The Medical Society of New Jersey, the General Assembly of New Jersey (meeting at Perth Amboy on September 26, 1772) passed an Act to "Regulate the Practice of Physick and Surgery." The preamble notes the many ignorant and unskillful persons administering "Physick" and practicing surgery. The Act provided for examination of candidates by any two Judges of the Supreme Court. These Judges were entitled to ask proper persons to assist with the examination and were paid a fee of twenty shillings by the candidate. If the candidate was successful, he was given a printed or written testimonial admitting him to practice. Monetary penalties were levied against those practicing without such testimonial. Men already established in practice were excluded from the necessity of taking the examination; and persons performing certain specific acts, such as bleeding, drawing teeth, or giving assistance for which the individual was not entitled to make a charge, were likewise excluded. Skilled physicians and surgeons from neighboring colonies if requested to render care on a particular case within the Colony of New Jersey were exempted from taking the examination. The Act stated that bills were to be rendered in plain English words. It also levied penalties against mountebanks on public stages.

The junior Dr. Jacobus Hubbard was graduated from the University of Pennsylvania and started practice with his father. He moved briefly to Gravesend on Long Island; but, after several years, returned to Monmouth County and established his practice at Tinton Falls. One of his manuscript ledgers[3] is still in existence and covers parts of the period between 1791 and 1811. From it we can surmise something of his practice, its problems, and his personality. The left hand page of the ledger gives an account of his services to each patient and the fees charged; and the opposing page, labeled "Per Contra," bears an account of payments received for services. Indicated also is the social and economic status of many patients, such as "blacksmith," "miller," "shoemaker," "slave," "negro man," "widow," "boatman," "merchant," "farmer," carpenter," "fisherman," "sawyer," "tailor" and "chairmaker." If the patient lived a distance away, his location was noted. The more distant points were Squan (Squancum), Freehold, Colts Neck, Shark River, "Rack Pond," and Middletown. This was indeed, a substantial area to cover on horseback with medical kit and instruments in the saddle bags. The total number of patients in the ledger is 350. The number of patients seen daily is small, averaging eight, in comparison with the thirty or more patients often seen during the course of the modern doctor's day. Dr. Hubbard was often called to treat several members of a family at one time. Because of the distance involved and the slowness of travel, the doctor would take three or more days making a circuit of patients at "Rack Pond," "Squancum," and Frechold, the total distance of the circuit being about 40 miles by the then existent trails.

With all this detail given in the ledger, it is interesting to note that Dr. Hubbard (and presumably his confreres) never indicated a working diagnosis. Strange also is that all sums are in pounds, shillings, and pence although this was fifteen or more years after the Revolution. However, this appeared to be common currency in many rural areas. Some of the services rendered and fees charged were as follows:

[3]Hubbard, Jacobus, jr.: "Manuscript Ledgers 1791 to 1811." In the possession of Dr. John Makin, Belmar, N. J.

Reducing fibula, 2 pounds; drawing tooth, 3 shillings; inoculating child, 1 pound, 12 shillings; delivering young wife, 1 pound, 4 shillings; removing fungus flesh with the knife, 6 shillings; reducing dislocation, 10 shillings; reducing inferior maxilla, 1 pound, 4 shillings, 6 pence; opening breast abscess, 7 shillings.

Note the fee for inoculating a child as compared with that for a delivery or for treating a fracture. Commonly, there were separate charges for the visit, emetics, dressings, and attendance. A common sequence of treatment for a patient requiring frequent visits and therefore quite ill was the following: first, administration of emetics, occasionally followed by cathartics; subsequently, if the patient remained under treatment, phlebotomy, performed over a period of time. The final stage of treatment was the administration of anodynes, after which time the name of the patient usually appeared no longer in the account book.

The "Per Contra" page indicates that a large number of fees were never collected and that many were paid only after two, three, or more years. Often patients made partial payments in such diverse goods as fish, shoes, a pig or two, or bushels of corn.

Dr. Hubbard was an energetic and popular practitioner as well as a civic leader. He was one of the four men who organized the Monmouth County Medical Society in 1816. He was its treasurer in 1816, secretary in 1819, vice-president in 1820, and its president in 1827.

A number of the County Society's problems would not be foreign to the present day Society. Two meetings a year were held in Freehold and were obviously not well attended. An attempt was made in 1823 to establish a penalty of $1.00 for absence. Defeated then, the penalty ruling was later passed. The Society also had a Medical Library which, however, fell upon evil days, the librarian reporting in 1835 that there were a large number of missing volumes. The lending library was finally abandoned; and the remaining volumes divided, by lot, among the members of the Society.[4] The membership strongly supported the temperance movement which was particularly active in Monmouth County.[4] New Jersey's first Temperance Society was founded in Allentown (New Jersey) in 1805. In 1835, the Society resolved that "No wine bills shall be paid out of the funds of the Society." However, an attempt similarly to prohibit use of tobacco failed in those pre-Cancer Society days.

Dr. Jacobus Hubbard, junior, was considered a paragon of medical virtue to whom younger men went for experience and council. One of these young men was Dr. John Morford, who apprenticed under Dr. Hubbard during the early 1820's and soon became a practitioner of renown. He died in 1839 at the untimely age of 36. A nephew, Dr. William H. Hubbard, was an apprentice in the mid 1830's and eventually succeeded his uncle in practice in Tinton Falls, continuing to minister to the sick and suffering in his area until his retirement in 1882. The good doctor's home still stands in Tinton Falls.

Because of the nature of medical education and practice prior to the early 1900's, the influence of the first Dr. Hubbard extended far beyond his admission to practice in 1765. The armamentarium of the successive apprentices remained during these years nearly identical. Only with the rapid advances in medical discovery during the 20th century and the ensuing adjustments in training were there any significant changes in method or equipment. Yet, if we examine the day-by-day problems of the present day general practitioner and the minutes of our local Societies, we find that a similarity of motivation, of certain illnesses, and of basic human nature make Dr. Jacobus Hubbard's medical practice in many respects quite familiar.

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[4]Ellis, Franklin: *History of Monmouth County*. Philadelphia. 1885. p. 234.

2100 Corlies Avenue

Parasitic infestations are no longer limited to the tropics. New Jersey—even northern New Jersey—may be wormy.

Parasites in Paterson

Richard Rosner, M.S./Paterson*

Parasitic infestations or infections are fast becoming a major medical problem in metropolitan areas. [2,4,5,6,9] The three major contributing factors are:

(a) The world-wide distribution of our armed forces and Peace Corps members in such areas as Africa, the Far and Middle East, Central America, and South America.

(b) The great speed and ease of modern travel along with the increase of leisure time. We now can go to—and return from such places as Mexico, South America and Central America for short vacation periods.

(c) The recent influx of immigrants from tropical climates where parasitic infections are endemic. These newcomers move mainly into metropolitan areas under crowded and unsanitary conditions.

For these and other reasons, there has been a large increase in the number of people who may harbor parasites. It can no longer be said that parasitic diseases are limited to tropical and subtropical areas. On the contrary, there has been a measurable increase in the incidence of parasitic infestations and diseases in our part of the country. [1 2 3]

Parasitic diseases present two separate problems. First, there is the disease itself; while the second problem is the detection of the disease. The latter is usually the more difficult. This is so because of:

(1) The fine line between infection and infestation.

(2) Often, the complete lack of symptoms.

(3) The lack of experience on the part of most physicians which might enable them to associate symptoms with possible parasitic disease.

(4) Shortage of trained laboratory technicians in identifying parasites.

(5) Lack of adequate material for teaching both the physician and the technician to recognize parasitic diseases.

The Study

In an effort to determine the incidence of parasitic infestations and infections in the local (Paterson, N. J.) population, it immediately became apparent that middle and upper income groups might not be sampled correctly. Lower income people are well represented by patients who attend the medical clinic and by those seeking jobs here at the hospital. Typical middle and upper income representation could be found only in private patients. The latter are not typical of the general population because they are all "medical" patients. To represent middle and upper income strata, we selected private patients from the obstetrical service. It was assumed that they had no "medical" disorders and that they represented a good cross section of the population from a health standpoint. This study was set up using the four groups as follows:

Group I—Private hospital in-patients with gastro-intestinal disorders. Financially, they were excellent representatives of the local middle and upper income group. However, from the standpoint of health, this group was not a good representation of this stratum.

Group II—People attending the medical clinic. Patients selected for this group all complained of gastro-intestinal disorders. They were typical representatives of lower income people. However, from the standpoint of health, this group was not typical. This group was used to compare and offset Group I in the study.

Group III—All people seeking employment at St. Joseph Hospital during the test period. This group was typical of the lower income stratum. It was assumed that these job applicants were healthy people.

Group IV—Private obstetrical patients. This group was an excellent representation of the middle and upper income families. It was assumed that these people were all healthy individuals.

*Mr. Rosner is a microbiologist at St. Joseph Hospital in Paterson, N. J.

These four groups represented a good cross section of the local population. Groups I and IV typify middle and upper income families. Group I represented those suffering from gastro-intestinal disorders, and group IV represented theoretically healthy individuals. Groups II and III represented lower income strata. Group II typified people suffering from gastro-intestinal disorders, and group III represented theoretically healthy individuals.

This study was undertaken because of the high incidence of positive findings in job applicants. To obtain a good representative sample of the local population, the four different study groups were set up. The study was carried out from August 1, 1963 through November 30, 1963. All people who fell into one of the four test groups during this period were examined for ova and parasites. The method of examination was by both the direct saline suspension method and the triton-ether-centrifugation method. All slides were examined as wet mounts and all were stained with iodine. When necessary, slides were stained with iron-hematoxalin.

When multiple infestations were found, the parasite considered most pathogenic was used for tabulation purposes. The results of this study are shown in the chart.

	SHISTOSOMA	TRICHURIS	DIENAMOEBA	ASCARIS	HOOKWORM	GIARDIA	ENDAMOEBA	E. HISTOLYTICA	PEOPLE TESTED	NUMBER POSITIVE	PERCENT POSITIVE
GROUP I Private G. I.	1	0	2	1	3	1	1	8	100	17	17
GROUP II Medical Clinic	3	14*	1	2	5	2	0	13	61	26	39
GROUP III Job Seekers	2	10*	2	5	11	3*	0	7	93	27	29
GROUP IV Private OB Patients	1	1*	3	2*	3	2*	0	12	171	19	11
GROUP I and IV	2	1*	5	1 2*	6	1 2*	1	20	271	36	13
GROUP II and III	5	24*	3	7	16	2*	0	20	154	53	34
GROUP TOTAL	7	25*	8	8	22	3	1	40	425	89	21

* indicates multiple infestations

Findings

As indicated in the chart, a much higher ratio of parasitic infestations or infections was found than might have been expected. Obviously, people in lower income brackets had a significantly higher incidence of positive findings than those in middle and upper income levels. In fact, the incidence is more than double that of the middle and upper income group (34 per cent overall positive in the lower income people while 13 per cent overall positive in the middle and upper income strata).

In group I, 17 per cent of the people tested were shown to have parasites. This is a fairly significant figure even in a group of people suffering from gastro-intestinal disorders. While this is a high ratio, if it is compared with group II, which corresponds to Group I (except for financial status) it is noted that group II has a 39 per cent positive finding. More than double that of group I.

In group IV, 11 per cent of the people examined had parasites. None of the people in this group had any symptoms or complaints which could be associated with a parasitic disorder. Comparing group IV with the corresponding subjects in the lower income group (group III), it will be noted that the incidence of positive findings is more than double at the lower income level.

The overall incidence for the entire study was over 20 per cent positive findings. This includes all four study groups. A total of 425 people were tested during the study period. While this is only a tiny fraction of the total local population, it is a good representative sample. The largest single parasite found was Endamoeba histolytica. In the overall study results, this parasite was found in almost half of the positive findings.

Conclusions

Lower income people in the Paterson (N. J.) area have a relatively high incidence of positive findings for parasites. While people in the upper brackets have a much lower ratio of positive findings, the percentage is still significant. The 425 people examined during the test period represented lower, middle and upper income

strata. The overall incidence of positive findings was over 20 per cent. This does not mean that 20 per cent of our local population have parasitic infections; it does mean that 20 per cent of the people tested had infestations or infections.

Acknowledgement

This study was made possible by the administration of St. Joseph Hospital, who allowed the testing of patients without charge.

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703 Main St.

Code Blue!

"Code Blue!"

Those two words, voiced urgently over an intercommunication system in Bethany Hospital in Kansas City, Kansas, may mean the difference between life and death. Code Blue is the emergency warning Bethany Hospital uses to alert a special medical team when a patient has suffered cardiac arrest.

If resuscitation can be started within four minutes of the time of oxygen stoppage, there is a good possibility that the heart and respiratory system can be made to work again.

When the signal Code Blue is given at Bethany, a team of six highly-trained personnel rush to the bedside of the stricken patient with a "crash cart" of special lifesaving equipment and supplies. Within seconds, the life-saving resuscitation is started.

Bethany devised its Code Blue operation back in 1961. It is described in the May 1964 HOSPITALS, Journal of the American Hospital Association, by Walter V. Coburn, administrator of the hospital.

The term Code Blue was adopted because the skin of patient who suffers a cardiac arrest appears blue. One of Bethany's three mobile units is in the operating suite. The other two are elsewhere but can be wheeled anywhere within the hospital in seconds.

Personnel in many departments of the hospital are trained in special procedures involved in Code Blue. The crash cart carries a portable electronic pacemaker, an external-internal defibrilator, medications, intravenous fluids, and sterile packs with instruments for tracheotomy or thoracotomy.

When cardiac arrest occurs in a patient *outside* the operating room, the nurse in charge immediately notifies the hospital's switchboard operator who sounds Code Blue. The first nurse to reach the emergency location starts external heart massage while another inserts an airway into the patient's mouth and begins mouth-to-mouth breathing. Seconds later, when the mobile cart arrives with its more sophisticated equipment and supplies, the Code Blue team takes charge.

Skill and knowledge gained through Code Blue emergencies made possible the opening in Bethany of a cardiac rehabilitation unit where most heart patients are admitted when they first enter the hospital. During the first six months, seven patients in the unit experienced unexpected cardiac arrest, and all were revived

In each of the four private rooms of the rehabilitation unit, the patient is protected by a built-in monitor-pacemaker at his bedside. Should the patient's heart stop, the monitor sounds an alarm while the pacemaker automatically stimulates the heart. A special wall microphone at bedside enables the nurse immediately to announce Code Blue. Team and crash cart arrive in seconds.

Smoking is bad for you; and so, it appears, is chewing gum. Here's how one man kicked the gum-chewing habit.

Headaches Caused by Excessive Gum-Chewing

Woodrow S. Monica, D.M.D./Orange

The constant, forcible contractions in abnormal grinding habits stimulate the masticatory muscles beyond their physiologic capacity. This may result in partial tetanies[1].

The following case report illustrates headaches caused by an unusual grinding habit.

In July, 1963, a 44-year-old man complained of recurrent bilateral headaches in the frontal and temporal regions for about seven years. He had consulted several physicians, including an otolaryngologist; they offered only temporary relief. In 1959 he was hospitalized for 11 days for a physical examination, including electro-encephalograms. These examinations and tests failed to reveal the etiology of the headaches. He had sound teeth, healthy oral tissues, and a functional occlusion. He was not aware of any abnormal grinding habit; but he chewed two to three packs of gum daily for about seven years.

I asked him to stop chewing gum. One week later, he had relief from headaches. He was examined periodically for five months and was symptomless.

Teeth do not make contact with the jaws at rest; but they do during certain physiologic processes. In chewing, the bolus lodges between the opposing teeth and prevents an enamel-to-enamel contact[2]. When the bolus is reduced in the latter stages of the chewing cycle, the teeth make contact when the mandible is braced against the maxilla for the distal swallowing thrust of the tongue. Teeth also make a momentary contact about 2,000 times a day when saliva is swallowed.

Excessive gum-chewing is non-physiologic. The soft, small mass stimulates the proprioceptive fibers in the periodontium to distort the pattern of neuromuscular reciprocal innervation. These excessive, afferent stimuli cause forcible, sustained contractions of the masticatory muscles that are beyond their physiologic capacity to resolve. And in tense, emotional persons, the constantly repeated contractions often result in partial tetanies of those muscles.

---

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310 Main St.

STATE ACTIVITIES

SMJAB

What do those letters mean to you? To your JOURNAL, they mean State Medical Journal Advertising Bureau. This unique agency is a cooperative of state medical journals, in which we of New Jersey participate. Most of our advertising of national accounts comes through SMJAB. The dynamo who has kept the SMJAB wheels turning for twenty years—and who was a functionary of its predecessor organization long before then—was Mr. Alfred J. Jackson. In July 1964, Mr. Jackson retired. The following tribute to Mr. Jackson was written by Dr. Stanley Weld, a past-chairman of the agency's advisory committee:

To Alfred J. Jackson upon his approaching retirement we pay our tribute to a man of sterling character, an efficient business executive who has carried on his duties with competence and unfailing good judgement.

Coming to the Bureau on the recommendation of the Trustees of the American Medical Association twenty years ago, he was then unknown to the editors and business managers of the journals comprising the Bureau. In a short period, Mr. Jackson won the confidence and respect of those with whom he came in contact and the Bureau flourished under his guiding hand.

It is with deep regret that the Bureau loses Mr. Jackson as its president. We herewith record our unanimous appreciation of his devotion to it.

May the coming years of retirement bring to him the rewards of friendships cultivated far and wide and may he long continue to enjoy good health and a happiness so well deserved.

SALEM'S OLDEST PRACTITIONER

Dr. William T. Hilliard was Salem's oldest practitioner. When he died, Dr. John S. Madara of Salem wrote the following tribute, which is here reprinted in full:

> By medicine life may be prolong'd, yet death
> Will seize the doctor too.
> —Shakespeare's *Cymbeline* (Act. V, Sc. 5)

Nine years ago I wrote a tribute to a good and faithful doctor who served the town of Salem well—Dr. David W. Green. Now another good and faithful servant has laid down his stethoscope and closed his eyes and ears to the troubles of this world and the complaints of his many patients—Dr. William T. Hilliard.

Not very often does a town merit the services of such men as these, each of whom have fit Sir William Osler's description of "that flower of our profession—the cultivated general practitioner." "Doctor Bill" was always and ever a gentleman—kind to his patients, polite to his colleagues, and generous to his friends. Work was his hobby. The babies he delivered in his lifetime would populate another town the size of Salem. Many a night he spent on a strange couch napping while waiting for a woman-in-travail to "push the head down a little farther."

On March 16, 1957, after 52 years of practice, he was given a testimonial dinner, but this did not slow him down. He continued to see patients until his recent illness took him off his feet. To keep abreast of modern treatment he attended the Tuesday afternoon seminars at Salem Hospital more regularly than some of his younger colleagues.

Although born a Quaker, he frequently attended the Presbyterian Church with his second wife, and it was a pleasure to be greeted by him after the service and hear him say with a twinkle in his eye, "It was good to see thee on time this morning!"

He knew people well—their financial straits as well as their personal problems, and for this reason often got down to the root of their symptoms. A description of "The G.P." by Dr. J. Pearse in the Lancet of 1919 describes his nearly sixty years of medical practice very well:

"He prescribes at birth and is sought in death, he knows of the skeleton which is hidden in most cupboards, he knows the tragedies which blast a life, and the minor discords which embitter it, he sees human virtue and human frailty, joy and sorrow, life in its seaminess and life in its excellence. Well for him if he can preserve a genial toleration for the frailties of mankind, and the spirit of charity."

And this genial toleration and charitable spirit he retained to the end . . . Salem will miss this kindly gentleman, this cultivated physician—"Doctor Bill."

ARE YOU READY DOCTOR?

—for the steadily increasing number of women who want the "Pap" smear as part of their regular checkups? By 1961, the number who had this cytologic examination had climbed to 10,000,000!

While the American Cancer Society's educational program has succeeded in alerting women to the vital importance of the "Pap" smear, it is the physician who plays the key role. This was confirmed in a recent survey of women who had had the "Pap" smear. It was revealed that 76% had it because it was recommended by a physician and 12% had it as part of a regular physical examination. Thus a total of 88% had it because of physicians' actions.

As the number of uterine cytological examinations rises, the death rate from uterine cancer declines. Most deaths from this disease could

be eliminated if these examinations were routinely performed. More and more women are ready for it and are willing to budget time and money for it. Are you ready for them, doctor?

The New Jersey Division of the American Cancer Society is ready to supply you with free "Pap" smear and biopsy kits. The New Jersey Society of Clinical Pathologists is ready to read the slides free for indigent patients. Write the ACS at 621 Central Avenue, Newark, N. J.

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LETTERS TO THE JOURNAL

Congress and King-Anderson

Dr. Albert G. Hulett of our Essex County Medical Society submits the following exchange of letters between himself and Congressman Minish of the New Jersey Eleventh District.

"Something needed for nothing"

My dear Mr. Minish:

Being "my" Representative in Congress, it will not be out of place for me to advise you that I and my family are unalterably opposed to HR-3920 (King-Anderson Bill) and respectfully ask that you vote AGAINST this bill when it comes to the floor. I have been asking my patients as they come into my office—and a majority are over 65 years of age—whether they favor this King-Anderson Bill. Strange as it may seem to you, in the hundred and more I have questioned, *not a single one* has expressed approval of it.

I shall not burden you with a recital of the reasons why I and these patients and my family oppose this legislation, except to state that, in addition to all the arguments against this bill which I could set down is the surprising fact—to those who may be pressing for its enactment—that amongst all of those whom I have questioned, I did not find a single individual who did not possess both hospital and medical-surgical coverage, either through Blue Shield-Blue Cross, or through some insurance policy.

It therefore seems to me that, aside from its attractiveness for some professional politicians (who think they can advantage themselves and their candidates by promising "something needed for nothing"), I do believe there is no need for this legislation which cannot be met by Kerr-Mills and private enterprise. I and my family and patients oppose any such widening of the federal bureaucracy as this bill would inaugurate; or any further taxation (which this bill will inevitably compel).

Sincerely yours,
ALBERT G. HULETT, M.D.

Reply from the Congressman: "High costs and low income"

Dear Doctor Hulett:

I appreciate hearing from you with regard to the King-Anderson bill, and I am truly pleased to know that your patients have adequate health insurance protection. Unfortunately, this cannot be said of the vast majority of Americans over 65. I would be delighted if private plans could meet the need, but the actuarial facts have doomed them to failure. The nature of the problem makes it impossible for any commercial insurance carrier or non-profit health plan to devise a policy that will adequately protect the aged, at a cost they can afford to pay. The proof of this lies in examination of policies now on the market. The best that private insurance has been able to do to solve the dilemma of high costs and low income (not more than 10 per cent of the aged have incomes over $4,000 and most of them have not yet retired and will have much lower incomes when they do) is to offer either low-cost policies with inadequate protection or more adequate policies that are priced out of the reach of most of the aged. The Blue Cross Association—the organization whose members have sold half the health insurance policies held by the aged—and the American Hospital Association have jointly announced their belief that *voluntary insurance alone and unsubsidized cannot meet the need.*

It is not promising "something needed for nothing" to advocate that, while earning, workers make small contributions to pay for protection against the high hospital costs that are a common occurrence in old age. They would have the protection at age 65 without need to make further contributions after retirement, just as the benefit of the present social security system meets the regularly recurring expense of food, clothing, and shelter.

The need is for a universal system of hospital insurance, covering all those who reach 65. This system can be made feasible, in terms of both costs and benefits, only if it is financed by contributions collected from people during their working years. Building on that minimum, the aged can individually, according to their means, buy private insurance covering medical and surgical expense, or, if they choose, supplementary hospital benefits.

The same arguments used against the King-Anderson bill were advanced against the Social Security Act of 1935. Experience with retirement benefits under social security allay all fears that a compulsory system means the end of our economic system, of the insurance industry, or of our democratic way of life. Social insurance has strengthened all of these, rather than the reverse.

With kindest personal regards, I am

Sincerely,
JOSEPH G. MINISH, M.C.

And Dr. Hulett adds: "Your thesis crumbles"

My dear Congressman:

I have your extensive reply and thank you for it. If that letter had been sent to someone who is uninformed about the matters you touch upon, its message might be very persuasive and your evident purpose would be achieved. However, I can perceive therein (and through the entire epistle) a succession of half truths, slight distortions, and entirely unjustified presumptions upon which the fabric of your thoughts rests. Once those factors are adjusted and

corrected, the whole of your thesis crumbles. It is truly amazing how adroit you are at constructing what seems (to the uninformed and unwary) to be a very logical argument predicated upon seemingly unquestionable facts. It is manifest to me that you have been doing such things for some while now, else your composition would not be so smooth.

What I have gleaned from your letter is that in this matter of the King-Anderson Bill (as also very probably in other items of similar nature) you will not be representing me, or other voters in the Eleventh Congressional District (as you were elected to do) but rather will be following the dictates of those bureaucratic politicians who intend to have this bill enacted into law. Furthermore, it is now clear that you deem it to be your privilege to tell me, and others whose wishes you are in Congress to serve, what I must think and must favor, or else confess myself to be idiotic and entirely illogical. I cannot subscribe to that idea.

I do not intend this letter to be unkindly at all. I merely wish it to clearly convey my thoughts to you. And it is, indeed, regretted by me that we are so very far apart in our thoughts and our convictions. Quite definitely you are not, and never can be, representing me in Congress.

I have repeatedly asked those who shed crocodile tears in public over the many aged poor who couldn't enter hospitals to send me the names and addresses of even only ten such who needed hospitalization and were refused. I never have received any answers, so I'll not ask you for such substantiating evidence.

Sincerely,
ALBERT G. HULETT, M.D.

A Plaintiff's Delight

Sir:

Here is a rebuttal to the article on page 93 of THE JOURNAL for March 1964. It was by Eli Scheer, M.D. of Teaneck, N. J. Here the good doctor assails "drugs" given to pregnant women. Nothing is spared. Everything from aspirin to sugar water—he implies—has, or may have, an effect on the fetus.

God help the pregnant women! God help the obstetrician beset as he is by rumors and malpractice suits. The article is a plantiff's delight. Picture this scene: It is the small hours of the morning. A woman has been admitted to the maternity suite with a diagnosis of abprutio placenta. An intravenous is started preparatory to the administration of whole blood. The attending physician arrives. A look of horror comes over his face. "Stop," he says, "don't you know that intravenous fluids can cause hyponatremia of the new born as well as alter the plasma osmotic pressure and disturb the newborn's plasma homeostasis? And you'd better not give her any blood, either; she could get homolgous serm jaundice, not to mention a transfusion reaction."

The scene now shifts to the obstetrician's office. Enter, a pale woman. "Doctor, I am 35 years old. I have lost five babies all at two months. I think I'm pregnant again. Can't something be done to at least give me a chance? I hear there are some new hormones . . ."

The doctor nods understandingly. "Yes, Mrs. Smith, there are the progestins. However, I won't prescribe them for you because they may cause fetal masculinization. You'll just have to take your chances."

Then there is Mrs. Jones who had a caesarean section and a convulsion, and lost the baby to boot. At least she did not receive any reserpine-like drugs which might have produced nasal discharge, costal retractions, lethargy and anorexia in the infant she didn't have.

One could go on *ad nauseam*. Any drug, no matter how innocuous, has had some side effect reported at one time or another. Coupled with the fact that most drugs are capable of crossing the placenta, this gives the obstetricians cornaries and the lawyers bigger tax returns.

Articles such as the one by Dr. Scheer do not give information, replete as it is with phrases such as, "may be due to," "have been suspected" and so on. To paraphrase a well known television program of a few years back: "Just the facts, man." The facts being when, how much, why, who reported it, how large the series, and so on.

By all means report drugs that have teratogenic implications; but cease and desist from articles composed of vague statements. Otherwise prenatal care, with all it has meant to maternal survival, may begin and end in the courtroom.

Dominic A. Introcaso, M.D.
Clark, N. J.

OBITUARIES

Dr. Joseph Chiaramida

After a long illness, Dr. Joseph Chiaramida died at his Brooklyn home on May 8, 1964. Born in Italy in 1891, he was graduated in 1915 with an M.D. degree from the University of Naples. In 1920, after a tour of duty in the Italian Army, he came to the United States, passed the New York State Boards, and practiced in New York City. In 1942 he accepted an appointment as a house physician at the Essex County Sanatorium in Verona, N. J. and joined the Essex County Medical Society. In 1957, at the age of 63, Dr. Chiaramida retired from County service and went to Brooklyn where his private practice was interrupted by his fatal illness.

Dr. William T. Hilliard

Salem County lost its senior physician with the death on June 30, 1964 of William T. Hilliard, M.D.—the "Doctor Bill" of South Jersey. He was born in Salem in 1881. In 1903 he won his M.D. at Hahnemann, and he interned at the National Homeopathic Hospital in Washington, D. C. He returned to his native county and served the people of southern New Jersey for over half a century. In 1957 he was the recipient of a testimonial dinner, which represented one of the largest outpourings of people in South Jersey history. That year, too, he was a Golden Merit laureate of our State Society. During World War I, he was a medical corps officer, serving on the Argonne front. He was a member of the Salem Friends Meeting, a director of the City National Bank, a staff official of the Salem Memorial Hospital, and an active worker in civic and religious activities throughout Salem County.

Dr. Mabel S. Haines

The long and useful life of Mabel S. Haines, M.D. came to end on the fourth of July 1964 with death that day of Mabel S. Haines, M.D. Born in 1883, she was a 1908 graduate of the Women's Medical College of Philadelphia. Her husband was William H. Haines, a well known South Jersey practitioner. Dr. Mabel Haines served as president of the New Jersey Women's Medical Society and also as head of our state's Federation of Womens' Clubs. She was a radiologist and roentgenologist—one of the first women in the country to enter that specialty, and taught the subject at her alma mater. She was also chief of roentgenology at the Women's Hospital in Philadelphia for many years.

Dr. Winfield S. Kilts

One of Bergen County's senior practitioners died on May 26, 1964 in Waynesboro, Virginia. Dr. Kilts was born in 1880 on the day Garfield was elected President of the United States. He was a graduate of the Albany Medical College, class of 1906. Dr. Kilts was a general practitioner, proud of being characterized as a family doctor, and for more than half a century served the people of Teaneck and vicinity, both in his office practice and in enthusiastic participation in civic affairs.

Dr. John F. McGovern

One of Middlesex County's senior physicians, Dr. John F. McGovern, died on June 2, 1964 at St. Peters Hospital in New Brunswick where he had long been a surgical consultant. Born in 1889, he received his M.D. at Albany in 1917. He had been a prominent athlete in Rutgers, class of 1913. An F.A.C.S., he had served at various times as City Physician and County Physician. He was also a medical officer during World War I. Dr. McGovern was also on the staff of the Middlesex General Hospital.

Dr. Morton F. Trippe

At the untimely age of 49, Dr. Morton F. Trippe, a past-president of the Monmouth County Medical Society, died on July 16, 1964. Born in Asbury Park, he received his M.D. at the Jefferson Medical College in 1940. After interning, he was accepted at the Atomic Energy Center in Oak Ridge, and was therefore accredited in the field of atomic medicine—one of the few New Jersey physicians to have that distinction. He was an internist on the staff at Fitkin, and served as president of the Monmouth County Heart Association. He was also active in civic affairs in Monmouth County and was on the county's Board of Adjustment. He was in charge of the radioisotope work at several Monmouth County hospitals.

BOOK REVIEWS

Clinical Immunology & Allergy. By Leo H. Criep, M.D. New York, 1962, Grune & Stratton, Inc. Pp. 582. ($18.75)

This is a first-rate reference book. The type is clear, large, and readable. The format is modern, the photographs excellent; and it covers completely the field of clinical immunology and allergy. Like all textbooks, however, in rapidly advancing fields, a good part of the text becomes outdated by the time the book appears in print.

You can learn how to do a diagnostic Frei test for lymphogranuloma inguiniale; or, if you're unfortunate enough to have an anaphylactic reaction, you can learn how to treat it. Dr. Criep even tells you how to make your own allergy extracts.

There are three major fields where I, and many other allergists, disagree with Dr. Criep.

1. In his routine allergy tests he lists 145 skin tests for foods. Few of us would do that many today, since food tests are notoriously inaccurate and do not have the reliability of inhalant tests. Some of us do no food tests, others, perhaps a dozen.

2. Dr. Criep says: "The emulsion treatment is feasible and practical." (This is the "one shot" or repository antigen treatment where the antigen is dissolved in oil.) Many of us do not feel it is ready. The *Medical Letter on Drugs & Therapeutics* (Aug. 31, 1962) states, "The failure, after so many years of trial, to develop generally accepted, standardized repository materials, and the doubts as to safety, do not commend the method for routine clinical use."

3. In a book of 550 pages on allergy, there are only 3 pages on psychotherapy.

Despite these criticisms, this book is worth a place on your library shelf.

Frank L. Rosen, M.D.

Maternal and Child Care. Report of the Medical Exchange Mission to the USSR. The United States Public Health Service. Washington, D. C., 1962, Government Printing Office. Pp. 140. ($1.00)

From October 15 to November 11, 1960, six prominent American physicians visited hospitals and clinics in the Soviet Union in a Medical Exchange Mission under the Zhukov-Thompson agreement. This paperbound booklet is a detailed report of their observations. It is divided into chapters on maternal, obstetric, and pediatric care and research; and sections on individual Russian medical facilities.

Personal observations are clearly distinguished from statements by Soviet hosts. The authors' interpretations are admirably objective and unbiased. They do not compare Russian and American medicine except in a few personal opinions of Russian medical research. The reader is left to his own comparisons and conclusions. I felt that a Russian physician (or politician) who read the pamphlet could have no complaint of inaccuracy; the picture of Soviet medical care that is here presented is clear and penetrating.

This book will be of interest to all interested in the care of children or pregnant women, concerned with public health, or concerned about international events.

Edward P. Duffy, Jr., M.D.

Law and Psychiatry: Cold War or Entente Cordiale? By Sheldon Glueck, LL.B. Baltimore, 1962, Johns Hopkins Press. ($4.95)

In these Isaac Ray Award lectures, professor Glueck analyzes the bases for communication breakdown between psychiatrists and attorneys. Concentrating largely on the criminal-responsibility dilemma, he proposes a formula of his own to replace the austere McNaughten rule and the somewhat amorphous Durham rule. Glueck suggests that the criteria be impairment of "powers of thinking, feeling, willing, or self-integration which probably made it impossible for the defendant to understand or control the act." He also proposes an intermediate verdict when the jury is in doubt: in addition to finding the accused guilty or

innocent, they could also find him "partly responsible."

Other matters discussed in this incisive monograph are the status of irresistible impulse (which, he argues, should be a valid defense even under the McNaughten criteria); the problem of free will and responsibility (especially with respect to a person's ability to intervene in the chain of causation); the practical effects of the Durham rule (in the District of Columbia, the only jurisdiction where it applies the verdict of "not guilty by reason of insanity" was rendered in 14 per cent of cases in 1961 but in only 0.9 per cent in 1953—the year before the rule was adopted); the American Law Institute's proposed formula; the problem of cognitive versus conforming concepts of responsibility and the role of the psychiatrist. In all, this is a meaty little volume that will stimulate thought.

Herbert Boehm, M.D.

Todd-Sanford Clinical Diagnosis. *By Laboratory Methods. Ed. 13. Edited by Israel Davidsohn, M.D. and Benjamin B. Wells, M.D. Philadelphia, 1962, Saunders. Pp. 1020 Illustrated. ($16.50)*

The present edition contains twenty-six chapters, four appendices, and an elaborate index. Especially timely is new material on statistical tools in pathology, isotopology, electrolytes, serum enzyme determinations, and hospital epidemiology. While most of the contents are useful and authoritative, it was our impression, that (particularly in the chapter on blood) some of it is impractical and antiquated and could have been deleted from a volume which otherwise appears modern. For instance, the practice of immersing blood lances in alcohol is obsolete and could have been omitted. The absence of a general formula for enumerating cells with a hemacytometer was conspicuous.

Certain technical points might be reviewed if another edition of this text is contemplated. The author's statement that oxalates used as anticoagulants cannot be heated beyond 80°C. could profitably be explored. The retractability of the clot in hemophilia is certainly not normal, and useful histologic information can be secured from bone marrow when the specimen is obtained longer than two hours after death. Similarly, erythroblastosis due to ABO sensitization has been shown to be ten times more frequent than erythroblastosis due to Rh sensitization.

In the chapter on isotopology, it would have been fairly easy to indicate the half-life of all isotopes discussed. The chapters on mycology, bacteriology, protozoa, helminth infections, and arthropods are highly commendable; the illustrations in this section are superb.

A slightly larger print, even if it necessitated an increase in size of the volume, would have been desirable.

The voluminous material presented is well-handled, and it is our impression that this text will remain for an indefinite period of time as a prized possession of every clinical pathologist, medical practitioner, and all students of microbiology. Those interested in the broad subject of public health, diseases of man or animals, will read the thirteenth edition with intellectual profit. T. K. Rathmell, M.D.

Enzymes and Drug Action. Ciba Foundation Symposium. Editors J. L. Mongar, Ph.D. and A. V. S. deReuck, M.Sc. Little, Brown & Co., 1962, Boston. Pp. 556. Illustrated. ($12.50)

The Ciba Foundation Symposium on Enzymes and Drug Action was set up with the purpose of bringing together the best ideas of chemistry, physiology, and pharmacology in relation to drugs, enzymes, and their function. In this symposium, there are papers and discussions by 71 international and outstanding authorities. At the end of each group of presentations is a round-table colloquium which is fascinating and unique in that the discussion is frank and uninhibited, and thereby most revealing.

As a reference book on enzymes, transport systems, hormone reactions in the body, as well as the actions of various drugs on these systems, one could not find a better rounded presentation. This is particularly true because of the fact that no presentation was left unchallenged. Therefore, it becomes readily apparent where

fact ends and theory begins. This enables even the novice in the field to find his way through the quicksand and pitfalls with a minimum of trauma. His hand is held, and he is led through the morass by the outstanding authorities in the field.

In the final half of the book there is a discussion of drug-enzyme interactions at molecular, subcellular, and cellular levels, giving a scope and depth of presentation which is unique.

The author index, as well as the subject index, is comprehensive and complete. This facilitates the use of the available material. The only adverse criticism one might have is that the type of paper and font style used make the text difficult to read for the bifocal and trifocal crowd.

The material in this book will be a basis for much of the future work in cellular pharmocology and biochemistry. It is, therefore, a valuable addition to any reference library since it will be used frequently by those involved in drug action as well as interaction with enzymes and hormones. Arthur Bernstein, M.D.

Curare and Curare-Like Agents. By A. V. S. deReuck, editor for the Ciba Foundation, Boston, 1962, Little, Brown and Company. Pp. 103. 31 illustrations. ($2.95)

Claude Bernard observed in 1850 that curare produced in animals a state wherein muscles could be excited and nerve impulses conducted, but not a junctional block prevented impulse transmission from the nerve to the muscle. One hundred years later this drug was just beginning to be used in clinical medicine. During the past twenty-five years, astonishing advances have been made in the subject of curare and curare-like agents.

This concise treatise contains five formal presentations by international authorities. Each presentation has a bibliography and is followed by an extensive discussion.

Some of the material presented details the fate of this drug in the body and the factors influencing its uptake and release. The physicochemical interactions of these agents at the receptor sites are qualitatively and quantitatively evaluated as well as the relationship of this effect to the chemistry of neural and muscular metabolic processes. Discrepancies between *in vitro* and *in vivo* studies are considered and clarified.

This book serves as a valuable research reference. It is a compendium of current theories as well as established facts in this specialized area of knowledge. A proper understanding and appreciation of it require advanced knowledge in biochemistry and pharmacology. In addition to scientists working in these areas, its further appeal is to physicians who employ these agents in their daily practice, particularly anesthesiologists. Joseph Anthony Cox, M.D.

Shock: Pathogenesis and Therapy. Edited by K. D. Bock. Springer-Verlag, Berlin, 1962. Pp. 387. Illustrated. ($13.00)

This is a remarkable book to be highly recommended to all interested in shock. Forty-one authorities in surgery, clinical medicine, experimental and clinical physiology, pharmacology, endocrinology, allergy, pathology, biochemistry, and biophysics participated in this symposium. Shock is discussed in terms of the mechanisms which can reduce the systemic arterial pressure, e.g. anaphylactic reaction, blood loss, loss of body fluids, traumatic injury, pericardial tamponade, crush syndrome, myocardial infarction, vasovagal fainting, peritonitis, orthostatic venous distention, and venodilation.

A modern view of the physiologic mechanisms which regulate systemic arterial pressure was presented by Dr. R. F. Rushmer. Harvard's Dr. J. Fine reported on his experiments which demonstrate that one can prevent the development of irreversibility and death from hemorrhagic shock. Dr. D. E. Gregg presented interesting findings on regional blood flow changes in conscious dogs upon bleeding and in the shock which subsequently develops. An increase in glucose-6-phosphatase activity in the liver and kidneys of shocked animals was reported by Dr. L. Migone who suggests that this enhanced enzymatic activity is mediated through the adrenal glands. There were several inter-

esting papers on the role of the kidneys, the participation of the adrenal glands, and the reflex regulation of cardiovascular mechanisms in shock. The use of adrenocortical steroids, sympathomimetic pressor amines, and vasodilator agents in the treatment of shock of varying etiology was discussed in great detail.

Each of the contributors has referred to a great deal of pertinent work in their respective fields and has been surprisingly successful in retaining coherency and fluency. This book is a useful reference work for those interested in shock. Harold M. Bates, Ph.D.

Pediatrics. Ed. 13. By L. Emmett Holt, Jr., Rustin McIntosh, Henry L. Barnett. Appleton-Century-Crofts, 1962, New York. Pp. 1395. ($18)

This thirteenth edition is the fruit of a monumental effort to bring together most of the current knowledge in the field. The authors retain those basic concepts which time has shown to be true; and have added recent knowledge that has earned acceptance on the basis of its merit. Of special interest is the chapter on the diseases of early life in which the approach to fluid and electrolyte management is particularly good. The section on nutrition reviews water and mineral balance in infancy as it pertains to the relative renal insufficiency at that age. A revision of the once standard indications for tonsillectomy is set forth. Included in a rather standard review of pulmonary diseases is an excellent summary of pulmonary physiology.

Worthy of mention is the clear-cut manner in which electrocardiographic findings are applied to clinical situations. The chapters on jaundice, diseases of the bone, infectious diseases, endocrinology, and emotional problems are excellent. Other sections of this major pediatric work have many commendable features.

Negatively, the reviewer found the print to be too small, and would suggest more photographs to enhance the value of so worthy a volume. All in all, however, this book is one which any practitioner of medicine would do well to include on his list of standard references. Douglas Ford, Jr., M.D.

Synopsis of Obstetrics. By Charles E. McLennan. Ed. 6. St. Louis, 1962, Mosby. Pp. 464. ($6.75)

Medical students, interns, and practitioners have been served well by this synopsis of obstetrics since it was first published in 1940. The fact that this is the sixth edition speaks well for the massive acceptance of this compact volume.

The late Jennings C. Litzenburg wrote the first edition shortly after retiring from active teaching at the University of Minnesota. It consisted of a set of lecture notes he had made available to his students and reflected his belief that the student learns best "by reviewing concise, pithy statements designed to arouse attention and arranged in outline form."

Dr. Charles E. McLennan, Professor of Obstetrics at Stanford University, does well in preserving the original flavor and intent of the book. He did make some changes, however, especially in re-arranging chapters into a more logical sequence—merging many related subjects that had previously been widely scattered. He deleted many outmoded, and he added some of the newer, obstetrical beliefs and practices.

This synopsis fails only where the subject matter requires a detailed and thorough understanding of the background of research such as is required on the chapters on ovulation and fertilization, endocrine functions in pregnancy, and Rh isoimmunization, to mention only a few.

Only confusion could be generated by trying to condense such highly theoretical subject matter into an outline form. From the sixth chapter on, however, when the book covers such subjects as diagnosis, prenatal care, postures of the fetus, clinical course of labor, etc., one begins to appreciate the original purpose of these compact lectures. These particular "concise, pithy statements designed to arouse attention and arranged in outline form" are the reason this book has been so well received in the past. These latter chapters, plus the 157 illustrations, make this a wonderful quick-reference book that will earn its keep on any doctor's desk or shelf. Anthony F. Palmeri, M.D.

ABSTRACTS

ON TUBERCULOSIS AND OTHER RESPIRATORY DISEASES. ISSUED BY THE NATIONAL TUBERCULOSIS ASSOCIATION

SEPTEMBER, 1964 • VOL. XXXVII, NO. 7

EFFECTS OF MEASLES AND MEASLES VACCINE ON THE TUBERCULIN TEST

Tuberculous children with measles, measles modified by gamma globulin, or vaccinated against measles had a depressed reaction to the tuberculin test, raising the question whether the vaccine may have a deleterious effect on undetected childhood tuberculosis.

Twenty-two tuberculous children in whom typical measles developed in the spring of 1962 were studied at Kings County Hospital Center. Seven were admitted with measles and found to have tuberculosis. Measles developed in 15 tuberculous children in the hospital, 8 of these being modified by gamma globulin. The measles was mild to moderate in all the children, with complications in only two—a pneumonia and a mild encephalitis.

In addition to these 22 children, two separate groups of tuberculous children were given live measles vaccine and studied in similar fashion. Group 1 consisted of 14 children who were exposed to a child with measles prodromes and given 1 ml. of live measles vaccine two days later along with gamma globulin, 0.2 ml. per pound of body weight. Group 2 consisted of 10 children without exposure to measles who were given live vaccine without gamma globulin. Nine of the children in Group 1 and 6 of those in Group 2 had clinical and laboratory evidence of vaccine measles. Each had significant antibody-titer changes.

All the children were given isoniazid and para-aminosalicylic acid (PAS) throughout the period of the study, which for each child was about a year.

All children were tested on the forearm every two or three days with freshly prepared PPD. Readings were made at 48 hours and recorded as the average diameter of induration. The criterion for a positive reaction was induration over 5 mm. in average diameter.

Depressed Reactions

Measles unmodified by gamma globulin was present in 14 of the 22 children with tuberculosis and measles. Seven were admitted to the hospital with measles, and measles developed in 7 during the hospital stay. Twelve of 13 children tested between the fifth and ninth day after the onset of rash showed negative reactions to tuberculin. From the tenth through the fifteenth day only 2 tuberculin tests of 8 were negative, and from the sixteenth through the twentieth none of 4 readings was negative. The average length of time before the tuberculin test turned positive was 18 days. One reaction was negative 42 days after the appearance of the measles rash.

In the 8 tuberculous children in the hospital who were exposed to measles and contracted gamma-globulin-modified measles, the tuberculin reaction became negative 12 to 22 days before the rash. Beginning with the fifth day after the appearance of rash, positive readings developed. The average interval before the tuberculin test turned positive was 17 days.

Among the children in Group 1, 6 of 14 with no exposure to regular measles were given live-virus vaccine and contracted definite vaccine measles. These children showed variable de-

Saul Starr, M.D., and Sumner Berkovich, M.D.; *The New England Journal of Medicine*, February 20, 1964.

pression of the tuberculin test, but in most the change was of shorter duration and of lesser degree than in natural measles or gamma-globulin-modified measles.

In addition, 9 of the 10 children in Group 2 were exposed to wild measles and given live vaccine with gamma globulin separately. All but 1 showed depressed tuberculin tests. In these children the combined effect of vaccine measles and incubating measles on the tuberculin test cannot be ruled out.

No Increased PPD Sensitivity

At no time, in any of the children studied, was a distinctly increased tuberculin sensitivity found in the incubation period. The tuberculin reaction was diminished in at least half of the readings in the incubation period of gamma-globulin-modified measles.

There was little difference in the tuberculin-test changes with regular and gamma-globulin-modified measles. The uniform depression of the tuberculin reaction in the first four days with rash and the appearance of a few positive skin tests in the next five days was confirmed. In both groups the interval during which the more dilute tuberculin tests were negative or depressed averaged about 17 days.

Since the depressed reaction to PPD during measles returned to its previous levels in all but 2 cases, we believe that desensitization from repeated testing was not a major factor.

Of the diseases that depress the tuberculin reaction, measles does so more uniformly and more strongly than any other. Any explanation of this effect must include the action of measles virus in the incubation period and for a period of weeks after full recovery. Fever and toxicity are obviously not the cause of the change in sensitivity. Since the tuberculin sensitivity may be depressed even when there is no rash, the exanthem of measles is not the critical factor.

The only children given measles vaccine who showed depression of tuberculin sensitivity were those in whom vaccines measles with evidence of increased antibody titer developed. Gamma globulin alone caused no such change.

Possible Explanation

It has been reported that early in the incubation period of measles lymphoid tissue throughout the body may be hyperplastic, and multinucleated giant cells are found in lymph nodes, tonsils, and adenoids, spleen and appendix. These cells are seen as early as five days after exposure to infection and appear to arise from lymphocytes. Since the measles virus produces such changes in lymphoid tissue and since the lymphocyte seems to be the cell involved in delayed sensitivity, one possible interference with tuberculin sensitivity may be a direct action of the virus on this function of the lymphocyte.

Another factor that must be considered is that the measles virus may cause an increased production of an anti-inflammatory steroid, which would then cause a depressed tuberculin reaction. This possibility requires attention because of the striking coincidence that measles can cause remission of nephrosis, can cause detrimental effects on the course of tuberculosis, and can depress tuberculin sensitivity. Furthermore, measles rarely causes asthmatic symptoms to flare up in children with recurrent asthma.

The relation of the changes in tuberculin allergy during measles to the possible deleterious effect of measles on the course of tuberculosis is only conjecture. Since vaccine measles in our cases depressed the tuberculin reaction, vaccine measles may also have deleterious effects in certain undetected and untreated cases of childhood tuberculosis.

NEW JERSEY TUBERCULOSIS AND HEALTH ASSOCIATION
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1. Welch, C. E., Diverticula of the Alimentary Tract, in Conn, H. (editor): Current Therapy—1961, Philadelphia, W. B. Saunders Company, 1961, pp. 224-225.

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NEPHROPATHIES SAID TO BE ASSOCIATED WITH ANALGESIC ABUSE

Over the past several years there have appeared in medical literature, particularly in Europe, reports of toxicities associated with excessive use of analgesics and analgesic mixtures containing drugs such as aspirin, phenacetin, acetaminophen, antipyrine, aminopyrine, caffeine, barbiturates and other sedatives. Because of this, the medical and research staffs of Burroughs Wellcome & Co. have conducted in their own research laboratories and in collaboration with pharmacologists, nephrologists, pathologists, hematologists, microbiologists in other institutions and medical schools, comprehensive animal and human studies to elicit more information concerning the mechanism of action, the usefulness and the extent of untoward effects of various analgesics.

Evidence Does Not Prove "Phenacetin" is the Causal Agent

The first report of possible toxic effects from long-term drug abuse came from Switzerland in 1953 where there was observed what appeared to be an increase in the incidence of chronic interstitial nephritis. The patients involved had taken a wide variety of drugs, including antibiotics and sulfas, and had also ingested over many years large quantities of analgesic mixtures. In this first report, one of the analgesic mixtures most commonly used to excess was a mixture containing 150 mg. isopropylantipyrine, 250 mg. phenacetin, 50 mg. 3,3,-diethyl-2,-4-dioxo-tetrahydro-pyridine (a sedative) and 50 mg. caffeine. Despite the complexity and excessive overuse of the mixture, plus the fact that patients were consuming various other drugs as well, "phenacetin" was arbitrarily designated as the nephrotoxic agent.

Other reports appeared, and with the passage of time the lesion most commonly associated with excessive use of analgesic mixtures was a chronic pyelonephritis accompanied in some instances by papillary necrosis. In these later reports other types of analgesic-sedative-stimulant mixtures were implicated. A formula often abused in Sweden contained 500 mg. antipyrine, 500 mg. phenacetin and 100 mg. caffeine; one in Australia contained approximately 7.8 gr. aspirin, 2.6 gr. phenacetin and 2.6 gr. caffeine citrate. It should also be noted that, according to the reports, persons abusing the analgesic mixtures in Switzerland, Sweden, Australia and elsewhere often took 10, 20 or more of the analgesic powders or tablets each day and for long periods of time. This is a lot of aspirin, antipyrine, phenacetin and caffeine to be ingested daily.

Though there has been this tendency to associate "phenacetin" arbitrarily with untoward effects of analgesic abuse, evidence available does not prove phenacetin as such is the specific causal agent. —*Continued*

Abuse in Europe, Australia and the United States

Apparently a great many more cases of analgesic abuse have been reported in such countries as Switzerland, Sweden, Denmark and Australia than in the United States. The "drug mixtures" commonly used and "abused" in these overseas areas have contained larger amounts of aspirin, caffeine, antipyrine, aminopyrine and other such drugs than would normally be found in formulas in the United States. For example, although it is rarely used here, extremely large amounts, 5 Gm. (75 grains) or more, of antipyrine or aminopyrine were consumed daily by persons in Europe.

Our extensive investigation of the literature and discussions with men knowledgeable in various ways about the problems of nephropathy lead us to believe that in the U.S.A. the number of cases of renal disease in which the abuse of analgesics may be implicated is relatively very small.

Analgesic Abuse - The Crux of the Problem

Based on the reports examined, there seems to be no sound evidence that phenacetin as such is specifically the cause of the cases of nephrotoxicity which have been ascribed to it. In the cases of toxicity reported, individuals consumed indiscriminately other analgesic drugs and analgesic mixtures and also the other drugs mentioned, such as stimulants and sedatives, in extraordinarily excessive amounts, chronically and for long periods of time. This would appear to be the crux of the matter.

Other Factors May Be Involved

Most of the clinical reports of nephrotoxicity assumed to be associated with analgesic abuse have resulted from retrospective studies. Findings from retrospective research may often be of value, but since one is dealing with a disease (pyelonephritis) of relatively high incidence (3% to 6%) and with drugs that are very widely used, it is possible that circumstantial evidence could lead to false or tenuous conclusions, both as to the causative factor and the magnitude of the problem.

A most important factor to be carefully considered is that many of the patients involved had bacteriurias and pyelonephritis, conditions that undoubtedly would have caused them to use analgesics for the relief of associated headache and "low-back" pain.

Also of significance is that a study of case reports shows that many of the patients with adverse reactions attributed to analgesic abuse had a multiplicity of functional and psychic disorders and had been using excessively a wide variety of drugs. These included not only analgesic mixtures but also sedatives, stimulants, antibiotics, sulfas and other antibacterial agents.

Acetic-4-Chloranilid - An Impurity in Phenacetin

Phenacetin produced in the U.S.A. is virtually free of acetic-4-chloranilid, a contaminant present in phenacetin produced in some other countries. The British Pharmacopoeia allows up to 0.17%, Denmark allows up to 0.35%. Burroughs Wellcome & Co. has a limit of 0.01%, and in most instances there is so little present the amounts are not detectable by the sensitive tests used. So far it is not known if acetic-4-chloranilid is a factor in the toxicities reported.

Studies of Toxicity, Action and Metabolic Fate of Analgesics

Nephrotoxicity of chemical agents is usually detected in experimental animals, but administration of high doses of analgesic drugs such as aspirin, phenacetin and acetaminophen, alone or in mixtures, to laboratory animals has not provided conclusive evidence of specific renal toxicity. Extensive studies with animals have been done and are continuing.

There has also been undertaken comprehensive research on the metabolic fate of phenacetin, acetaminophen and related compounds in both animals and man, and it is hoped that eventually this work will provide useful information.

So far the effect of excessively high doses of analgesic drugs and mixtures given to laboratory animals for long periods would appear to be one of lowering resistance to bacterial infection. It is probable that many drugs ingested excessively could result in a lowered resistance to infection.

Aspirin and Phenacetin - Analgesics of Low Toxicity

It is our feeling that aspirin and phenacetin, both of which have been used extensively for over 60 years, are:

Effective, useful analgesics and antipyretics.
Drugs of low toxicity.
Unlikely to cause harmful effects when used sensibly in doses as recommended.

Why the 'Empirin' Compound Formula?

Based on present knowledge, we believe it is unlikely that any replacement for aspirin or phenacetin could, in the long run, prove to have significantly lower toxicity. *We also believe that satisfactory analgesia with fewer possible side-effects is achieved when aspirin and phenacetin are combined in smaller amounts than would normally be used if each were taken separately.* This is the pharmacologic basis for combining the two analgesic drugs, aspirin and phenacetin, in 'Empirin' Compound.

In respect to this, it is interesting to note what Goodman and Gilman have to say on page 313 of their book, "The Pharmacological Basis of Therapeutics":

> "As emphasized for barbiturates and again for salicylates, a smoother and more efficient analgesic action may be obtained by prescribing a mixture of two or three analgesic chemicals. These should be selected from different classes of drugs and the dose of each reduced to one half or less. This represents one of the few valid uses of drug combinations. The possibility of untoward reactions is also reduced because the toxic effects of the salicylates, pyrazolon, and para-aminophenol derivatives differ somewhat from each other."

When used in moderate doses, as recommended, 'Empirin' Compound and its combinations with Codeine Phosphate are reliable, effective and safe analgesics for the relief of pain and headache. They have a long record of usefulness and safety.

—*Continued*

Conclusion and a Recommendation

Though authorities have stated there is no public health problem when analgesics are used sensibly, Burroughs Wellcome & Co. will continue to conduct and collaborate in further animal and human studies.

We also recommend that all members of the health team and the public be alert to the fact that harmful effects can result from misusing all drugs, including analgesics.

To discourage abuse, labeling of 'Empirin' Compound has included for many years a statement that adults should not take more than 6 tablets in a 24-hour period. To further minimize possible misuse, we have added a statement that if pain persists or recurs frequently, the patient should consult his doctor. There is also a warning on the label that 'Empirin' Compound, like all medicines, should be kept out of the reach of children.

* * *

A Review and Bibliography Available on Request

We have investigated in depth the reports of nephropathies alleged to be associated with the abuse of analgesic drugs and analgesic drug combinations. As a result of these investigations and discussions with many physicians and investigators expert in renal physiology and renal diseases, a Review and Comprehensive Bibliography on Analgesic Abuse has been prepared. We hope the information in it will help bring this complex subject into better balance and perspective. A copy is available on request.

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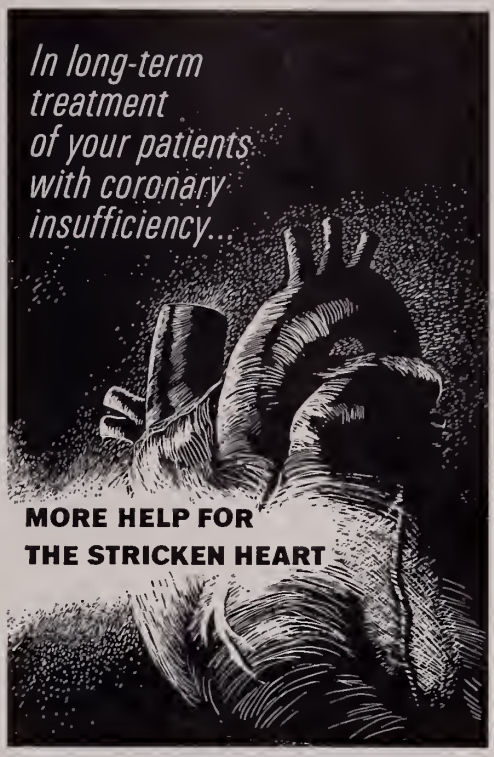
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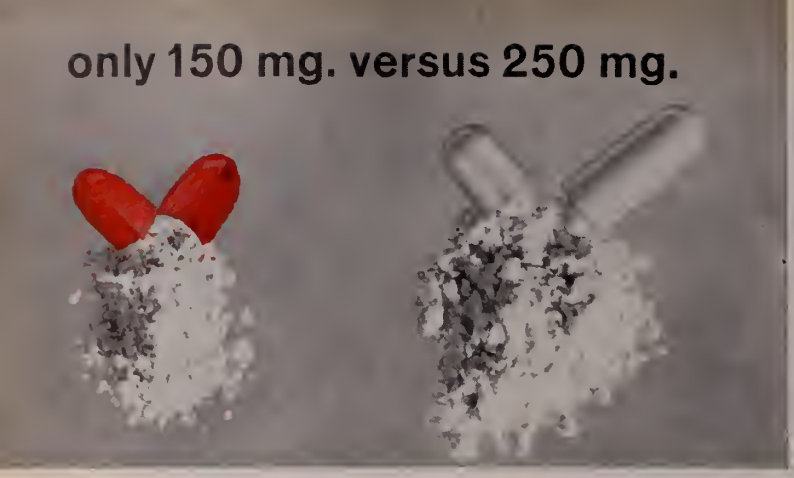
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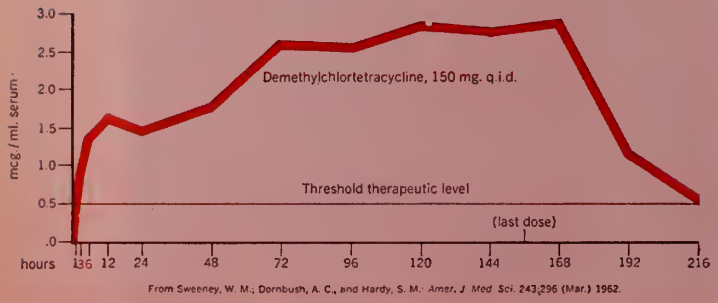
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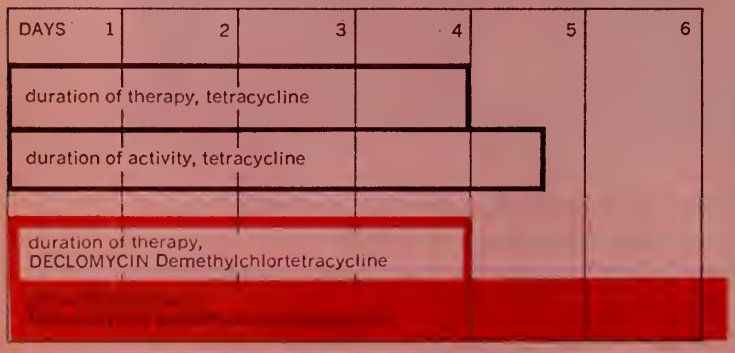


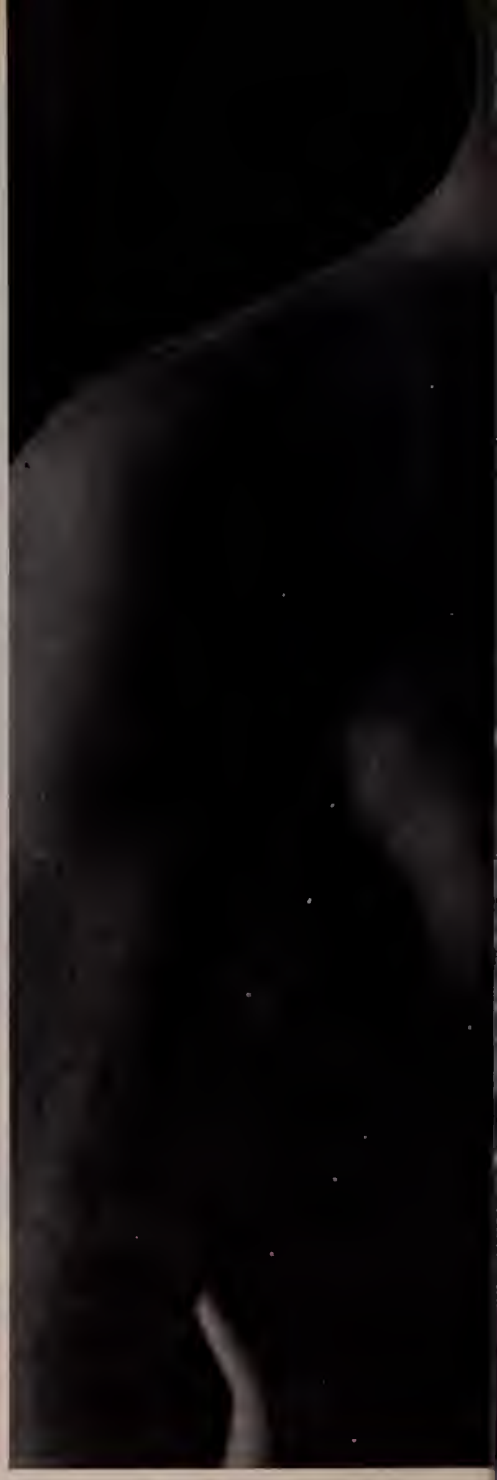
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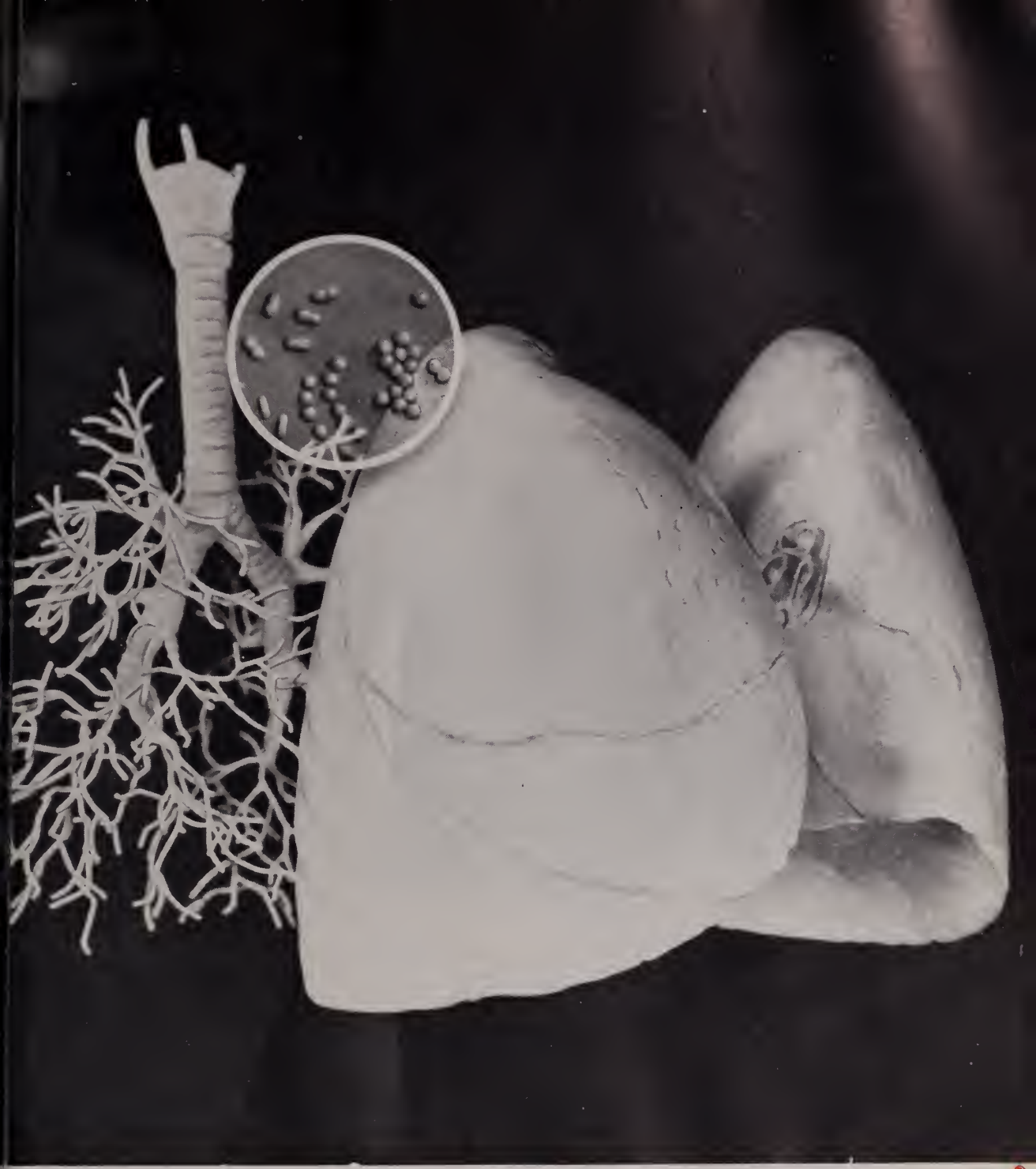
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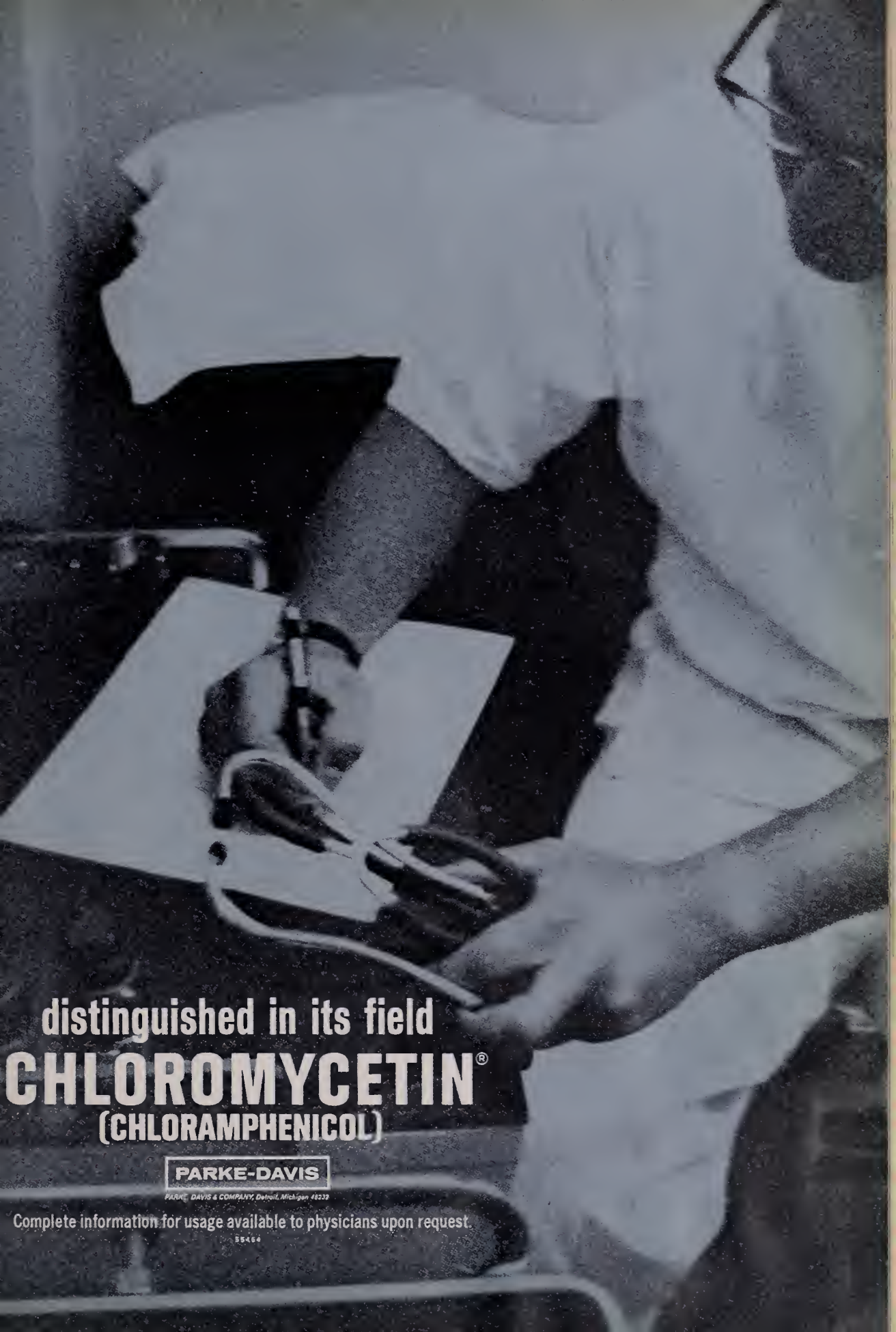
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Clinical Meeting: Philadelphia, **Nov. 28 - Dec. 1**
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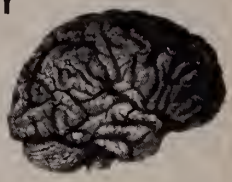
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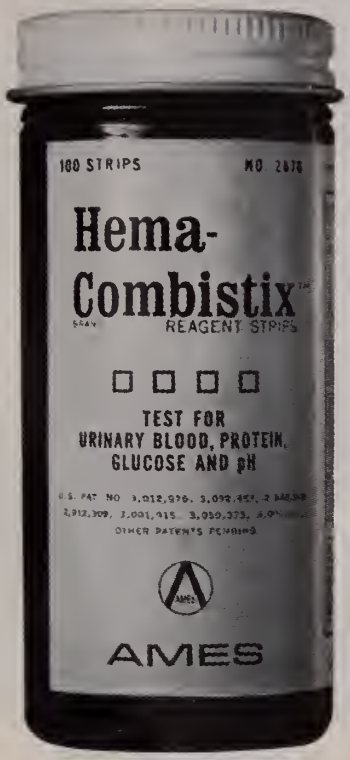
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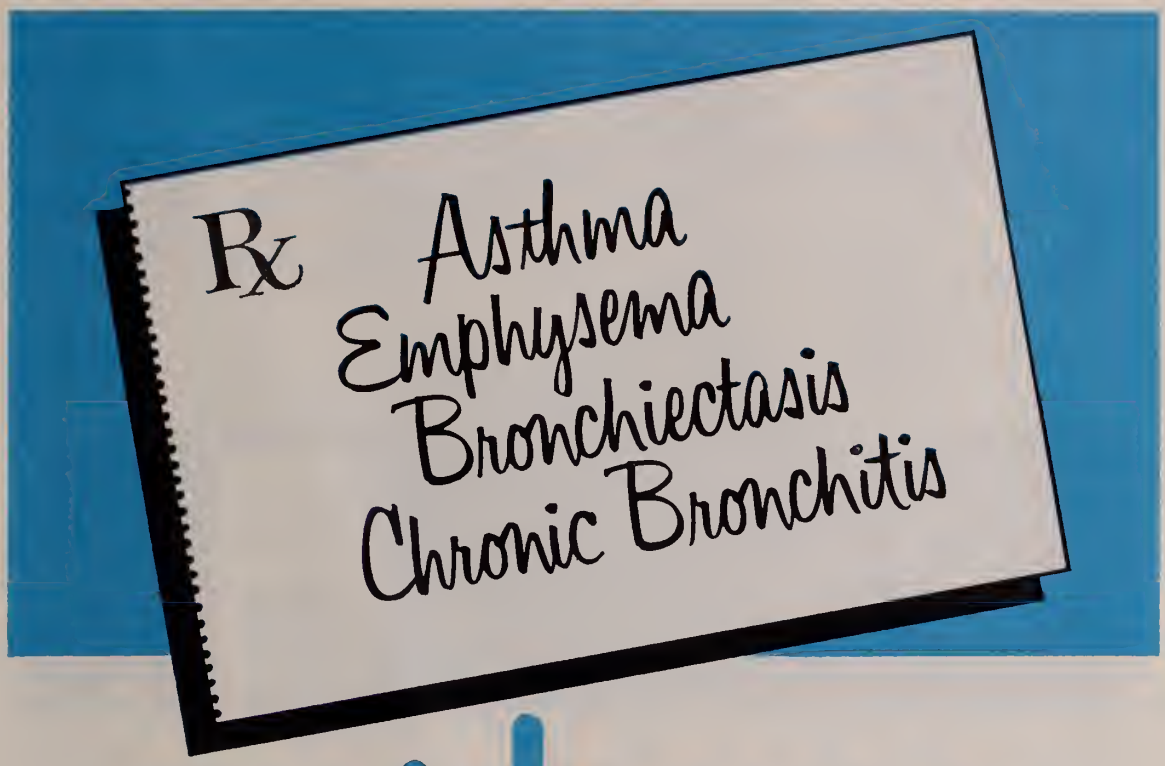
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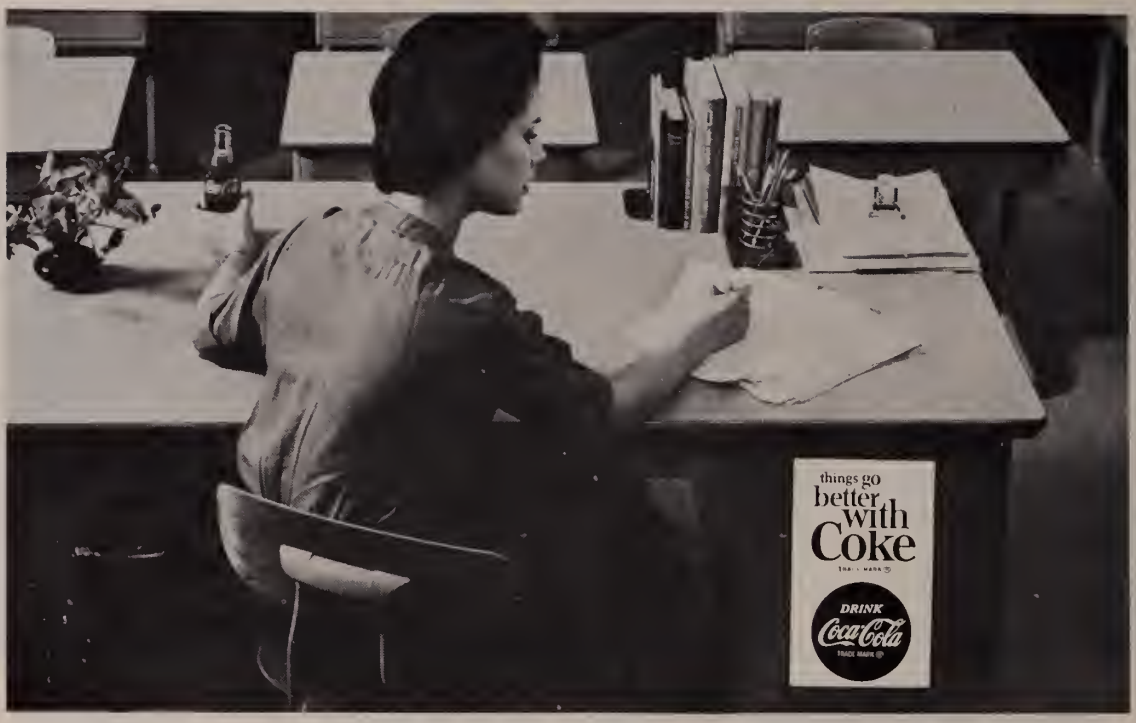
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AMA Council on Foods and Nutrition: Composition of Certain Margarines, *JAMA* 179:719 (March 3, 1962).



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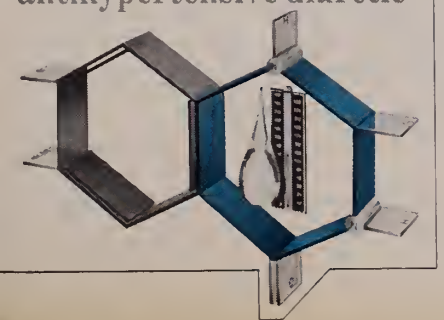
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CONTRAINDICATION: Anuria.

1. Steigmann, F., and Griffin, R.: Evaluation of Quinethazone, a New Diuretic. J. Amer. Geriat. Soc. 11:945 (Oct.) 1963.

2. Schwartz, M.: Office Evaluation of a New Diuretic in Patients with Hypertensive Diseases. Scientific Exhibit Presented at the Clinical Meeting of the American Medical Association, Los Angeles, California, Nov. 25-28, 1962.

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EDITORIALS

Medical Education in New Jersey

New Jersey cannot afford to lose its one operating medical school. Many such schools give admission preference to citizens of the states which subsidize them—and in those schools, at least, New Jersey doctor-aspirants will be under-represented. Many of our own citizens at out-of-state medical schools wind up in out-of-state internships; and then professional or romantic factors lead them to permanent placement outside of New Jersey. We can't indefinitely allow this kind of doctor drain.

Thus, the recommendation of the Governor's Fact-Finding Committee makes good sense and merits our support. They want the State to take over the operation of Seton Hall College of Medicine and Dentistry—and they want the transition to occur smoothly, swiftly, and without break in the continuity of producing practitioners. Any other plan would mean that, for some years at least, no new M.D.'s would be developed in our state. It is the prime purpose of a medical school to produce medical practitioners to take care of sick people. This mission, Seton Hall, as an ongoing school, has performed well—and no matter what changes are made in the name and control of the school, this function should be allowed to continue without losing time or momentum. The need is urgent, and the occasion will not wait. Let us all support this recommendation.

Nothing in this proposal need detract from Rutgers University's plan for a medical school sited on a university campus. New Jersey can well support two medical schools. (Massachusetts, with a smaller population than New Jersey, supports three.) We can leave to later consideration problems of the permanent physical location of the newly retitled New Jersey Medical School. What is needed here and now is assurance that there will be no interruption in the education of physicians in New Jersey.

Survey on Retirement Plans

In this issue of the JOURNAL is a postcard calling for information on you—as an employer. This survey is needed in connection with the possibilities of developing a good retirement plan.

The attention of the 1964 House of Delegates was called to the fact that there are benefits to be derived from any plan if a physician employs no more than one person. If a physician employs more than one person, the benefits begin to decrease. In view of this, the reference committee recommended—and the House approved—a resolution to the effect that a survey of our members be made to determine the number of physicians who have no employees or employ no more than one person.

The House felt that such a survey would help the Committee to decide whether a retirement plan for members of MSNJ should be instituted.

Your Medical Society is studying this and can give you sound information about it—on one condition: that you—the members—give us the facts. So don't disfranchise yourself, and don't contribute to a skewing of the survey, by failing to send in the postcard. Do it now!

Drug Research Espionage

One of the odd factors in drug cost is the manufacturer's expense for maintaining security measures. One does not, ordinarily, think of chemists and other scientists as wearing cloaks and using daggers to prevent espionage. Yet consider the testimony of Merck and Company's administrative vice-president, Mr. Fred Bartenstein. "The science spy is as new as penicillin and the transistor," Mr. Bartenstein told the annual convention of the American Society for Industrial Security, citing recent thefts of secret data concerning drugs.

Mr. Bartenstein stressed the difficulty of protecting new break-throughs in science and technology. There is evidence now unfolding, he said, "of multiple rings (and he didn't mean benzene rings) with centers here and abroad, and with ready markets for stolen data."

Those who steal and use industrial secrets, he said, reap rewards from "innovations they do not make, and will in the end discourage and destroy innovation."

Calling for stronger laws to protect the research findings and technical know-how of U. S. industry, Mr. Bartenstein said that "undeterred theft of these commodities not only weakens those scientists and organizations that do the best work, but it also adds intolerably to the already large risk of research."

Here is another complication which, inevitably, must reflect in the cost of drugs.

Sometimes it isn't anything as dramatic as espionage. It's just that when a formula or process is published, foreign companies can duplicate it—without having spent any money on research. This gives them the edge, so that they can undercut American prices. But sometimes, it represents real espionage, too. Life in the drug industry is never dull.

Communicated Emotions

Psychiatrists know about *folie a deux,* a dramatic communication of delusions. The false ideas are not transmitted by germs or by physical contact. They move on the wings of words and thoughts only. But they are transferred just the same. And on the positive side, we speak of an infectious smile—a communication of good cheer from one person to another. There are practitioners who can make a patient feel better simply by walking into the room. Their magic seems to be totally unrelated to the doctor's education or intelligence. In a vague way we ascribe this to the physician's "personality"—or to his "bedside manner." Many quacks and cultists can line up devoted patients by the dozen to give zealous testimonials. They, too, communicate confidence and cheerfulness.

The patient's will to live, or the patient's giving up in defeat, may quite literally make the difference between life and death. The doctor's own self-confidence, and his ability to radiate it (observe that adjective *radiant*), become a life-giving force.

One need not be a mystic to stress this. Emotions can cause changes in tonus, vascularity, and secretion. These, in turn, can affect the biochemistry, the physiology, and ultimately even the structure of tissues and organs. Hinkle and Wolff* demonstrated that "the reaction of a man to his life situation plays a role of significance in many episodes of *physical* disease. An increasing proportion of therapeutic effort will have to be directed towards the patient's relation to his environment if we are to make significant improvement in health. Even cancers of fibrous tissue might be responsive to profound sociologic disturbances that caused hormonal changes in the body."

Our vocabulary can frighten people. A concussion, as we doctors know, is a reversible, transient condition. But to the layman, the word conjures up images of serious brain damage. Heart disorders can be mild—"functional", if you will. But to the layman the phrase "heart disorder" will induce anxiety and convey terror. And medicine is a "drug" in our lexicon; but to the unsophisticated, the latter word suggests an opium den or a coma-inducing drug. "Spine" is just another word to us, but it can produce anxiety in an uneducated patient.

Emotions rain down on us—they leap out of the television screen, out of the newspaper, out of the colored advertising in magazines. Our ears and eyes are endlessly assailed by words and pictures deliberately fashioned to provoke emotional responses. A whole new profession has been created which has its purpose in influencing the thinking and mood of human beings. It is either education or brain-washing, depending on whether you approve or disapprove of the goal.

Doctors can no longer console themselves with the thought that they are but craftsmen of the human machine. They have to know about the infectiousness of ideas, words, and smiles as well as the infectiousness of bacteria. Pollen in the air can cause symptoms; so can hatred in the air. And we are doctors to the total man.

* Quoted by Golin, M.: Journal of The American Medical Association, 171:182 (Sept. 12, 1959)

In these four pages, Dr. Satulsky offers us a practical monograph on geriatric dermatology.

Dermatologic Problems in The Elderly*

Emanuel M. Satulsky, M.D./Elizabeth

The skin may be a mirror reflecting internal disease and morbid processes. The skin is also a protective barrier between man and his environment, and is thus subject to all manner of noxious influences. Thus, we are dealing with cutaneous disorders, not merely treating skin diseases. Let us direct our skills and training in diagnosis and therapy not only to the skin but the patient living within it.

These axioms are particularly true when we encounter the normal cutaneous changes of the elderly, which although of many types, are basically degenerative. In evaulating these changes, we consider the patient's age and the type of skin with which he was born; his general health and habits; his occupation; the climate in which he has lived and the degree to which he was exposed to physical agents—especially wind, cold, heat, and sunlight. Because of reduced skin elasticity in the elderly, the skin loses its tone and becomes furrowed, thinned, and wrinkled. In individuals previously obese, the skin may hang in folds. Alterations in pigmentation may occur with hyperpigmentation of the body folds and a diffuse yellowish or waxy-pale color of the entire skin. There may also be dryness, loss of lustre, scaliness, small angiomas and telangiectases, and alterations in the density, texture, growth, and color of bodily hair. The nails may also show alterations in texture and become dystrophic. Onychogryphosis of the toenails is a common finding.

New Growths

In addition, an ever-increasing number of elderly patients are concerned with new growths on their skins, either for cosmetic reasons or because of an understandable fear of malignancy. It is essential that we learn how to differentiate between benign and malignant neoplasms and that we recognize precancerous lesions.

From a clinical standpoint the recognition of these lesions is most important. For the benign lesion, reassurance is solacing and treatment is offered only for cosmetic reasons. Premalignant and malignant lesions require adequate removal or destruction. In treating cutaneous malignancy in the elderly, a thorough evaluation of the patient's general condition is necessary. It may be best for the patient to remain ambulatory. Then, disabling surgical procedures which would confine him to bed or limit his activities should be avoided. However, in most cases, surgical excision or electrosurgical procedures are valuable tools of treatment. X-rays are especially valuable as they avoid injection of a local anesthetic. X-ray radiation is painless, easily administered, does not require dressings, and does not interfere with the patient's activities. With proper technics of shielding and depth estimation, results are excellent, with few recurrences and smooth pliable scars. This modality is sometimes complicated, however, by the need for getting elderly patients off and on a treatment table, persuad-

*Read before the Section on Dermatology, The Medical Society of New Jersey, May 1963.

ing them to remain in one position for proper shielding and exposure (despite support with sand-bags), and in having them return daily or on alternate days for treatment.

Keratoses

Two keratotic lesions of the skin have long been a source of confusion. They are seborrheic and senile keratoses. Each has its own clinical and histologic picture. They require different management. *Seborrheic* keratoses may appear at any age, but occur with increasing frequency in older people, particularly in darker skinned individuals. They are asymptomatic except for itching and pain, which may result from friction and trauma. The evolution of seborrheic keratoses is slow. They tend to increase in number. There is no tendency to spontaneous involution. Cancer rarely develops from seborrheic keratoses. I have never seen such a case. However, a recent report[1] indicates that 1 to 2 per cent may become basal cell epitheliomas. Ravits[1] lists seborrheic keratoses as precancerous lesions. In most cases, the mass is covered by a greasy scale that shows follicular plugging. The lesion may be dry and warty on the face, or soft and friable where macerated and traumatized. Irradiation is not effective in the seborrheic keratoses and has no place in their treatment. Effective methods include light electro-dessication, coagulation, and curettage; solid carbon dioxide, or the local use of such chemicals as trichloracetic or monochloracetic acid. My favorite technic is ethyl chloride or Freon® spray to produce solid freezing, followed by curettage with a sharp curet and local use of freshly prepared Monsell's solution. This leaves excellent cosmetic results and can be accomplished with a minimum of pain or discomfort.

Senile keratoses, although they occur most often in the elderly, may also be found in younger people whose skins have been subjected to wind, sunlight, and the elements. They occur most frequently in fair-skinned patients on areas most consistently exposed to the elements. They are slightly elevated and covered, usually with a dry adherent scale, removal of which leaves a raw bleeding surface. The skin on which these lesions are found often shows other aging processes such as wrinkling, dryness, and thinning of the skin. Inflammatory changes in a senile keratosis should arouse suspicion of a malignant change; and certainly ulceration, rapid growth, or erosion of the surface requires prompt investigation. These lesions have a disposition to become squamous cell carcinomas and have an estimated malignancy rate of 15 per cent. Radiation is not advised in the treatment of senile keratoses. They are best treated by destruction with electro-dessication, coagulation, electrocutting, or surgical excision by scalpel. Care must be exercised in two respects: (a) adequate removal of the potentially dangerous lesion, and (b) prevention of other lesions as a result of exposure to sunlight, local irritants or chemicals. Other factors in good management are emollient creams and lotions, superfatted soaps, careful periodic observation of the vulnerable skin and sun-screening preparations.

Pruritus

Pruritus in the elderly is often explained as being due to senile changes in the skin. It may appear in association with arteriosclerosis and is accompanied frequently by other complaints, such as tingling, burning, or crawling sensations. The first step in determining the etiology of generalized pruritus is a complete and careful examination of the entire skin surface, since many obvious dermatoses frequently cause itching. Failure to find an adequate explanation for the symptoms must intensify the reevaluation of the history and an exhaustive review of the general medical status of the patient. Look into the possibility of drug ingestion and applications of external medicaments. Elderly patients may be vague, often fail to remember facts clearly, and tend to minimize everything except their present complaints. Bathing habits must be accurately ascertained as well as the type of underclothing worn. Does the pruritus occur when there is a change in environment—such as overheating, undressing, or exposure to sunlight? Pruritus hiemalis (winter-itch) is a frequent winter complaint of elderly people who bathe too often, have little humidity in their homes, and wear shorts or brief underwear.

If no external explanation for the itching is found, the search must be intensified and must include attention to a detailed medical evaluation of the patient. The investigation should include a survey of the kidneys, liver, hematopoietic system, and diabetes mellitus. A recent report[2] indicates that the intractable dermatoses may reflect chronic urinary infection, probably due to a renal auto-immune mechanism. In a series of 20 patients, dermatitis that appeared with recurrent urinary infection cleared when the infection was treated. None of these patients had eruptions of the skin prior to the onset of the urinary symptoms. Pruritus is the most common cutaneous symptom of internal malignancy and is a common feature of the lymphomas, particularly Hodgkin's disease, mycosis fungoides, and the exfoliative form of chronic lymphatic leukemia. Generalized itching occurs in malignancies of the abdominal organs and has been reported in cancer of the breast, brain tumors, and lymphosarcoma.

Laboratory studies may include a complete blood count with determination of uric acid and glucose tolerance tests; urinalysis; liver function and protein-bound-iodine tests; x-rays of the chest and gastro-intestinal tract; stool examinations and biopsies of the skin, lymph glands, and bone marrow.

Treatment: Colloid baths of various types, such as oatmeal or starch—with or without the use of the new dispersible bath oils like Alpha Keri®, LuBath®, Geri Bath®, or Oilated Aveeno®—are frequently of great help. Avoidance of soap in some cases and the use of a superfatted soap, or of soap substitutes, in others may be indicated. Thickening and scaliness of the skin may necessitate careful use of various tar baths with meticulous observation of the patient for excessive dryness or possible sensitivity to the tar. The elimination of drugs, local medicaments, suspected foods, wool, and coarse materials is also important. Local applications of wet dressings, lotions, liniments, emulsions, and bland ointments are soothing when indicated and properly applied.

Sweat retention caused by occlusion of the ducts causes inflammation and intense itching. In elderly people, particularly, this is intensified when sweating is stimulated as by an increase in temperature. This has been observed in atopic dermatitis, exfoliative dermatitis, and seborrheic dermatitis and may be caused by superficial maceration and edema of the horny layer. In addition to this, the trauma and possible secondary infection resulting from scratching, plus circulatory and metabolic changes in the elderly skin, all create an interaction of factors which may strain the therapeutic skills of the treating physician.

Acetyl salicylic acid and other salicylates are effective measures in the treatment of pruritus. Sedatives containing barbiturates and chloral hydrate may be needed for relief. Barbiturates do not relieve itching, but they do dull the higher centers needed to inhibit the scratch reflex. Avoid any drug which may have irritating or sensitizing possibilities in the treatment of the pruritus or the secondary infection which may result. Consider the phenothiazines—such as Tacaryl® hydrochloride or Temaril®, which contains Trimeprazine®; Periactin®, a serotonin, or a histamine antagonist. Antihistaminic preparations (except for a mild sedative effect) are not the excellent antipruritic agents they were once thought to be. Local applications of steroids have a place in the management of many cases. For long-term systemic steroid therapy, dexamethasone is the least suitable unless weight gain of the patient is unimportant; triamcinolone over a long period may produce a loss of weight and actual muscle wasting; prednisone and prednisolone have an effect somewhere in between. All these drugs have the same anti-inflammatory effect with different side effects in terms of the patient's weight and sodium retention. Long-term use of steroids is limited to patients in which their use may extend life and give relief to otherwise intractable symptoms. Their usual use is in the patient who has acute, severe, rapidly progressive dermatitis which cannot be controlled with routine therapeutic measures. Adequate dosages should be administered with rapid decrease and discontinuance as soon as feasible. Foreign-protein products and other agents which may produce fever and discomfort are not advised in the treatment of pruritus, although the use of auto-hemo-therapy may be a valuable procedure because of its non-specific protein effect.

Herpes Zoster

Prompt and adequate management of herpes zoster in elderly people must be stressed. In these patients, a persistent and agonizing postherpetic neuritis often develops. Such individuals seem prone to develop neuritis preceding the skin lesions and may present symptoms simulating renal colic or acute appendicitis. Herpes zoster is probably due to a virus. Other theories[3] have been proposed in its causation associated with internal cancer and lymphomas, such as (1) irritation of nerves by toxins, (2) compression by tumors, and (3) prolonged neuritis.

Local treatment is designed to dry the vesicles and protect the hyperesthetic area of involvement. A thick shake lotion is applied during the early stages and is followed by local use of an astringent paste as the acute phase subsides. Salicylates and codeine or even Demoral® and morphine may be needed during the early stages to control pain. Some recommend autohemotherapy, x-ray to involved nerve roots, intravenous use of pituitary extract, and sodium iodide. All these, in my opinion, are probably valueless in most cases beyond the suggestive effect. Intramuscular thiamin chloride 200 mg. daily, or Protamide® (a sterile aqueous colloidal suspension of proteolytic enzymes), are of value when administered early. Steroids are of definite help when used early in large doses to cause a more rapid regression of skin lesions and in prevention of neuritis; ACTH gel, given intramuscularly 80 units on the first day and then 40 units daily for 4 days, followed by steroids by mouth as long as necessary. In extreme cases neurosurgical blocking procedures may be considered. These include alcohol injections or other procedures, such as sympathectomy or section of sensory nerve roots. There have been some reports on the use of DHE 45® (dihydroergotamine methanesulfonate) intravenously or intramuscularly, but untoward effects have been cited. These include hypotension, headache, nausea, vomiting, and temporary bradycardia. Another valuable agent, chloromycetin in doses of 250 mg. by mouth every four hours for 24 hours, must be mentioned. In addition to its antibiotic effect, it causes marked regression of pain in many elderly patients with herpes zoster.

Bed Sores

The use of animal skins with the hair side turned towards the patient is effective in preventing decubitus lesions in elderly patients confined to bed. Similar precautions are desirable in those who spend a great deal of time in a wheel-chair. The original material recommended was sheep skin. Recently deer hides, pelts of the merino and cross-bred sheep have been used to accomplish the same purpose. The hair of the pelts permits circulation of air, flow of perspiration, and dispersal of pressure. Thus, the three prime sources of decubitus lesions (pressure, moisture, and friction) are reduced. The skins cannot be sterilized, but they can be washed with cool water and Woolite®, and rinsed with vinegar before being allowed to dry in the air. A sturdy synthetic fabric (Decubicare Pad®) is said[4] to have some advantages over animal skins. This soft, white, furry material has a one inch pile and is resilient and pleasant to touch. The pad is non-allergenic and non-inflammable. It is resistant to staining and soiling, does not support bacterial growth, and can be easily laundered. Cut into desired shapes and sizes, the fabric may be used as an undersheet; or cut to cover the seat, back, or heel rests of a wheel-chair. The use of this material has resulted in complete healing or great improvement of decubitus lesions in elderly patients.

Genital Lesions

Genital lesions are important post-menopausal complaints. Differential diagnosis is essential, since it is often difficult to distinguish between leukoplakic vulvitis, pruritus vulvae with lichenification, and lichen sclerosis et atrophicus. Kraurosis vulvae is simple senile atrophy. It is *not* precancerous. The terminology is confusing, since conditions presenting thickening and whitening of the vulvar skin (as well as shriveling of the labia with intense pruritus) have also been referred to as leukoplakic vulvitis, leukokraurosis, and chronic atrophic dermatitis of the vulva. There has been a great deal of conjecture about the cause of this syndrome. Avitaminosis, estrogen deficiency, and chronic vulvovaginal infection have been blamed as causative factors. Of the many dermatoses af-

fecting the vulva, the diagnosis of kraurosis carries with it the most sinister connotation. Epithelioma of the vulva has been found in chronic cases. It is my feeling that the constant trauma particularly associated with repeated scratching and rubbing is a greater disposing factor in the development of a malignancy than is the kraurosis vulvae itself. Thus if pruritis is kept to a minimum, epithelioma will rarely follow. Consideration must be given to underlying factors such as vulvar infections, vaginal infestations, and vitamin deficiencies. When there are raw denuded surfaces, local applications of ointments frequently increases irritation and maceration. Sitz baths, soothing wet dressings, and bland pastes will prepare the skin for the local use of estrogenic ointments containing estradiol or ethinyl estradiol. These are of great value. Steroids and antihistamines have been used locally with great success in addition to systemic use of large doses of Vitamin A and Vitamin B complex. Estrogens (orally or by injection) do not produce benefits equal to those obtained when they are used locally. Kraurosis vulvae may be completely arrested and the vulva restored to normal in early cases. Long-standing cases are irreversible. Nevertheless, treatment should be carried out faithfully to control the severe itching, which will eventually lead only to progressive deterioration. Estrogen therapy may frequently be complicated by yeast-like infections, since the estrogen causes glycogen deposition in the vaginal mucosa and increases the acidity of vaginal secretions. Such infections can usually be controlled by appropriate therapy, including boric acid or sodium bicarbonate douches. Lichen sclerosis et atrophicus may simulate kraurosis vulvae and may remain confined to the vulva; however, as a rule the lesions extend to the perineum and about the anus in a characteristic key-hole distribution. Similar lesions may be found on the shoulders, upper back, breasts, and sides of the neck as pearly-gray flat plaques. This is a benign condition which may be left alone and for which for many years there was no effective therapy. Bismuth, antimalarials, estrogens, androgens and Vitamin A have all been tried; steroids and Premarin® creams have been used locally with some degree of success. The most promising results are obtained by local injection of steroids. I have used this with fair success in 8 patients using a 0.5 per cent triamcinolone diacetate preparation. Others[5,6] have reported similar encouraging results in the intradermal use of steroids. Everett and Coffey[7] advocate the injection of 5 per cent chloroquin dihydrochloride. Accurate diagnosis, clinically and histologically, is essential to avoid extensive mutilating surgical procedures for this benign local condition in the vulvar area.

Leg Ulcers

Many conditions, particularly in the presence of arterial insufficiency and varicose veins, must be evaluated in the diagnosis and management of leg ulcers in the elderly. Trauma, obesity, infections with fungi and streptococci, and systemic causes, such as diabetes mellitus and anemia, must be considered. Malignant changes may occur in the margins of an indolent ulcer. Biopsy should be taken from the edge of every ulcer which does not respond to adequate therapy. Stasis dermatitis is a common finding in those who have had varices, previous attacks of phlebitis, or any local or systemic condition which produces edema in the lower extremities. Auto-eczematization is the complication to be feared as a result of hypersensitization of the skin elsewhere than on the legs with the development of a localized or even generalized eczematoid dermatitis. Treatment may require a long period of bedrest, elevation of the lower extremities, wet dressings, and local applications. Well-fitting supportive stockings or bandages applied before the patient gets out of bed each morning will encourage him to move more freely and prevent stasis of blood by muscular activity of the legs. Many patients will develop stasis hemosiderosis, which is a localized hyperpigmentation of the legs and requires no treatment. However, monobenzyl ether of hydroquinone (available as Benoquin®) can be tried for its bleaching effect—watching very carefully for irritation or sensitization.

Surgical Procedures

A number of surgical procedures are available for aging skin. These include corrective plastic

planing, chemosurgery, cryosurgery, and electrosurgery. These methods have been used to eradicate precancerous and malignant changes of the skin and to produce a more youthful appearance. Cosmetic preparations may improve some of the effects of the aging process and prevent or slow-down others. They may also relieve some of the emotional and physical discomforts connected with aging. Excellent papers [8 9 10] have been written on these subjects.

How about *biopsy* of the skin in elderly patients? Biopsy is not only a diagnostic procedure but an aid in prognosis as well. It is appropriate in the presence of new growths or non-infectious inflammatory reactions of the skin. Chronic ulcers may require biopsy of an edge to rule out malignancy or chronic granulomas, such as tuberculosis, syphilis, or deep mycotic infections. A generalized exfoliative dermatitis may prove to be Hodgkin's disease, leukemia, or mycosis fungoides. A chronic eczematoid patch may show the changes of Bowen's disease. Warty vegetative lesions, nodules of various shapes and colors, and many pigmented lesions are best biopsied to obtain a histologic examination.

Conclusions

We should bring to elderly patients all therapeutic measures of established merit. We must avoid becoming investigators for every new drug and proprietary preparation which we cannot properly evaluate scientifically. Some of these may produce adverse reactions in a patient whose skin has already lost its normal resistance and needs careful management at best.

TABLE 1

Commanly observed benign growths of the skin:

1. Seborrheic keratases
2. Papilloma calli
3. Pigmented nevi
4. Senile angiomas (ruby spots)
5. Xanthelasma
6. Sebaceous adenamas

TABLE 2

Commanly observed precursar lesians af skin cancer:

1. Senile (actinic) keratoses
2. Leukaplakia
3. Arsenical keratases
4. Kraurasis vulvae
5. Cutaneaus harns
6. Erythraplasia af Queyrat
7. Kraurosis penis
8. Bawen's precanceraus dyskeratosis
9. Xeroderma pigmentosum

TABLE 3

Malignant lesians af the skin:

1. Basal cell epitheliama
2. Baso-squamaus cell epithelioma
3. Squamaus cell epithelioma
4. Superficial epitheliamatasis

TABLE 4

Less Commanly Observed Malignant Lesions:

1. Paget's disease af the nipples
2. Melanoma
3. Metastatic grawths fram underlying malignant lesions ta the skin
4. Intra-epidermic epithelioma
5. Bowen's disease (alsa included under precancerases)

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737 North Broad Street

The simple system for the use of the ophthalmoscope should assist general practitioners in getting more out of their diagnostic equipment.

The G.P. and the Ophthalmoscope

B. Bernard Gurland, M.D./Bayonne

The use of the ophthalmoscope, as taught in medical schools, is so superficial as to be of very little value. It is taught primarily for use in the examination of the ocular fundus. The student is given elaborate descriptions of papilladema, diabetic neuritis, eye findings in nephrosis (Wilson Kimmestiel disease), and so on; but he is taught *what* to see before he is told *how* to see it. Proper and daily use can be helpful to the physician in almost every general field and many specialized fields; in the diagnosis of hypertension, diabetes mellitus, arteriosclerosis, almost all neurologic and intracerebral diseases, blood dyscrasias, nutritional and systemic toxins, syphilis, and tuberculosis. With some instruction and considerable practice, most doctors can detect abnormalities in the fundus of the eye; and then, if necessary, refer the patient to appropriate specialist. Fundal abnormalities can be signs of generalized diseases which are more simply observed by examination of the fundus than by lengthy and prolonged tests. Only when the abnormality is specifically an eye problem need the physician refer the patient to an ophthalmologist.

The ophthalmoscope described in this article is an outgrowth of the original Helmholtz reflecting ophthalmoscope invented in 1851. It is the direct method and is the most readily available and simplest to use.

The first essential to proper use of the ophthalmoscope is adequate illumination in the instrument; the second essential is a darkened room. An instrument with poor illumination makes it difficult, if not impossible, to observe the fundus. For best results, use an electric ophthalmoscope with a rheostat. If the room is not dark, the lighting will be reflected from the cornea and will interfere with light reflexes, making the examination difficult.

The third essential to good and easy examination is the instillation of a mydriatic.* Atropin should never be used because of the danger of precipitating glaucoma. About five minutes should elapse after drops are instilled, before examination begins. This may be used for making other tests necessary to the completion of the general examination. The aperture in the ophthalmoscope should correspond to the size of the patient's pupil. Thus, if the patient has a small undilated pupil, the aperture should be small. If the pupil is partly dilated, the aperture should be a little larger. For a fully dilated pupil, use a large aperture. Generally, it is best to examine with the pupil fully dilated, with a large aperture. This eliminates disturbing reflexes from the cornea and makes the fundus more easily visible. If the pupil is not fully dilated (especially in blue eyed patients), the light in the instrument may cause the pupil to become small and further interfere with the examination.

The patient should remove spectacles but the examiner should wear his. Both examiner and patient should be seated, the examiner to the right of the patient and slightly above him. The right hand of the examiner holds the instru-

*I prefer Mydriacyl® made by Alcon Laboratories of Fort Worth, Texas; or Cyclogel® made by Schieffelin of New York. Each is available in 1 per cent preparation—B. B. G.

ment when examining the right eye. Both eyes of the patient are open, and he is asked to look straight ahead, fixing at a given point in the distance, with the unexamined eye. The examiner places his left hand on the head of the patient. The left thumb is used to raise the upper lid. This prevents patient from moving his head away and helps examiner to steady himself. With the patient and examiner comfortably seated, the examiner at the right (using his right hand to hold the instrument), the examination of the right eye begins. Establish a routine of examining the right eye first; then go on to the left eye.

Step One

With the illuminated dial of the instrument on zero, the examiner, seated 6 to 8 inches away, looks for a reddish orange glow. This "fundus reflex" or "glow" is a reflection of the fundus. The intensity of the glow is evidence of a clear view of the fundus. If the glow is absent or pale, it is probable that there is some obstruction either in the exterior of the eye or along the visual axis. Most diseases which can be diagnosed through the ophthalmoscope are seen in the interior portion. However, if there is an obstruction of any sort in the exterior portion, it is impossible to see the interior. You will not see the fundus if there is a hemorrhagic mass in the anterior chamber, a very small pupil, lens changes, a dense corneal opacity, or a fibrinous mass in the vitreous. If the fundus is not visible in one eye, examine the other eye and then return to look again at the first eye.

Step Two

After observing the reddish glow, with the knarled head on the black "plus 20," the examiner, holding the instrument 5 centimeters from the eye, will focus on the iris lens diaphragm. At this point he will examine the iris, pupil, and anterior lens capsule, under magnification of a "plus 20" diopter convex lens. If the examiner backs away to 6 or 7 centimeters, he will see the anterior chamber and cornea under magnification. If the cornea is opaque or the anterior chamber is filled with opaque material, the iris cannot be seen. If the examiner then comes forward to 1 or 2 centimeters, he will see the nucleus and posterior lens capsule and the anterior part of the vitreous, all under magnification. Or he may remain in the same position but decrease the numbers down to zero, where he should be viewing the fundus.

Step Three

With the instrument on zero and holding the instrument as close as possible to the examined eye, a lighter colored, somewhat circular demarcated area should be seen. This is the optic disc. It is also possible to locate the disc by picking up and following a retinal vessel to the back of the eye, where it ends at the disc. About 2½ disc diameters laterally is the macular area. This avascular area can best be found by having patient look directly into the light. Most diseases of consequence in diagnosis would be seen in the optic disc and macular area and in the blood vessels. This area is known as the posterior pole of the eye.

The Dynamometer

An expansion of the use of the ophthalmoscope and also helpful for diagnostic purposes is the ophthalmodynamometer. This provides a visual means of determining the blood pressure of the internal carotid and intracerebral circulation. This pressure will sometimes differ from the systemic pressure. The instrument, however, is helpful only if the ophthalmoscope is used properly. With the ophthalmoscope focused on the blood vessels at the optic disc, the examiner places the ophthalmodynamometer on the sclera of the eye and presses until he sees the retinal vessel collapse. This is the systole. He then gradually removes the pressure until he sees the vessel pulsate. This is the diastole.

Conclusion

This simplified method for the use of the ophthalmoscope should be a considerable help to the physician in general workup and diagnosis. He will find that the time given to its use will be small compared to the information the examination will provide.

146 West 37 Street

Hardly anything is 100 per cent in medicine. But, according to Dr. Beer, this comes close.

Contraceptive Efficacy of Norethindrone with Mestranol

New Low Dosage Form

Morton A. Beer, M.D./Morristown

Of recent years, the synthetic progestins in combination with small quantities of estrogenic substance have come into increasing use for a variety of gynecologic disorders. When administered on a cyclic basis (i.e., from the fifth through the 24th day of successive cycles), the combination is generally believed to inhibit production of pituitary gonadotropin, to suppress ovulation, and to produce pseudodecidual change in the endometrium. The progestin-estrogen combinations have been found valuable in the control of various menstrual disturbances, such as amenorrhea, menorrhagia, and dysmenorrhea, and in endometriosis.

However, potentially the widest and most important practical application stems from the capacity to prevent conception by virtue of the inhibition of ovulation.

A number of studies[1,2,3] beginning several years ago and ultimately encompassing many thousands of treatment cycles initially established the contraceptive efficacy of norethindrone 10 milligrams and mestranol 0.06 milligrams per tablet.* The subsequent commercial availability of this strength of tablet provided a further broadening of clinical experience and even more widespread confirmation of its contraceptive reliability.

Within a relatively short period after release of these original reports, two further studies[4,5] were published, offering evidence that, as a means of contraception, norethindrone with mestranol tablets of substantially reduced progestin content were as effective as the 10 milligram tablets. The tablet used in these latter studies contained, indeed, only 5 milligrams of norethindrone but a slightly increased dosage of mestranol, namely 0.75 milligrams.

Recent reports[6,7] describe the results obtained with norethindrone with mestranol tablets of still lower progestin content. The tablets* used in these latter studies contained only 2 milligrams of norethindrone and 0.1 milligram of mestranol.

The strength of tablet in these studies appears to have made no fundamental difference to the clinical findings. In all of the 7 studies reviewed,[1,2,3,4,5,6,7] embracing collectively more than 1500 women observed through more than 20,000 cycles, there was only one instance of pregnancy reported by a patient who said that she had been taking the tablets regularly.[1] For all practical purposes, on the basis of the reported results, the reliability of the preparation as a contraceptive is virtually 100 per cent for all three strengths of tablet.

Certain incidental effects have also been noted with some regularity. In all studies, the routine has involved administration of one tablet daily from the 5th through the 24th day of the menstrual cycle, counting the first day of bleeding as Day I. In virtually all cases, this schedule has resulted in uterine bleeding starting a day or two after the termination of each cycle of administration. In only a small proportion—

*Available as Ortho-Novum® Tablets 10 milligram, Ortho Pharmaceutical Corporation, Raritan, New Jersey. A 2 milligram size is also available.

and then only on odd occasions—has such bleeding failed to occur. The bleeding episodes closely resemble normal menstruation except that the flow is generally less. Also, dysmenorrhea when previously present has frequently been relieved. Regardless of dose, some patients manifested slight breakthrough bleeding or spotting between the regular cyclic bleedings.

This has been seen in about one third of patients. It seems largely restricted to the first three to four months of therapy. The incidence falls off sharply even after the first cycle of treatment. Symptoms of gastrointestinal intolerance also have been noted in a not inconsiderable proportion of patients, but like breakthrough bleeding, the reaction appears with greatest frequency in the early cycles of treatment. Liability diminishes as therapy proceeds. It is seen only rarely after the third treatment cycle. Other phenomena associated with treatment that have been noted with some constancy are tendency to weight gain and mild increase in libido, the latter possibly attributable to relief from fear of pregnancy. In a very small proportion of patients, complaints have been made of hot flushes, acne, breast fullness or tenderness, and depression. As with all drug studies, subjective reactions such as headache and fatigue have been reported by some patients but these have been at a minimum when questions were couched in such manner as to avoid suggesting specific reactions.[3]

In no instance has norethindrone with mestranol been directly implicated as the cause of thrombi, embolism, or malignancy; nor has its use been followed, at a later date, by delivery of any female infant with signs of masculinization. Side-reactions with this therapy have posed no problem of real importance. Most of the subjects who dropped out of the various studies did so for extraneous reasons having nothing to do with drug effects.

Source of Patients

All patients included in the study have been drawn from the author's private practice. Predominantly they have comprised individuals of middle income group, living in an urban community of moderate size. All patients were Caucasian.

No rigidly defined criteria were applied in selecting patients. No patient was placed on therapy unless she was a married woman whose fertility was proved by prior pregnancy or could be assumed on the basis of general good health and the absence of any apparent factor likely to hinder conception.

A total of 87 patients has been placed on therapy. The subjects ranged in age from 18 to 43 years with an average of 30. All but six had previously experienced one or more pregnancies. Collectively, the 81 patients who had previously conceived accounted for 268 pregnancies (3.3 average per patient). Of these, 227 had proceeded to term with birth of live children. In 42 instances, pregnancy had terminated in abortion; but four patients, each of whom had experienced 5 abortions, accounted for 20 of the total.

Technic

Since patients have been gradually added to the program, there is considerable individual variation in the duration of treatment. At one extreme, one patient completed 19 cycles of treatment; and at the other, two patients at the time of reviewing results had not completed their first cycle. In total, the experience has encompassed 604 cycles of treatment, representing an average of 7 cycles per patient (Table 1). In fact, 51 (or 59 per cent) were maintained under treatment for 6 months or more; and 22 (25 per cent) for 12 months or more.

The schedule of treatment corresponded with that of other investigators. The medication consisted solely of norethindrone 2 milligrams with mestranol 0.1 milligrams. Initially, the patient was given tablets enough to last for 3 cycles. She was carefully instructed to take one tablet nightly from the 5th through the 24th day of her menstrual cycle, counting the first day of bleeding as Day I. She was advised that menstrual-like bleeding would occur within a day or two of stopping the tablets, and that she was to resume the tablets on the same cyclic basis five days after this bleeding started. She was told that if she noted any breakthrough bleeding or spotting between the regular "periods," she was to increase her dosage to

two tablets daily for 4 successive days. If no period occurred within 8 days of cessation of tablets, the patient was instructed to again start a 20 day cycle.

All patients prior to the start of their medication were given a meticulous physical examination. Thereafter, patients were requested to return for additional tablets at intervals of 12 weeks. At this time, a written report was obtained. Whenever possible, no oral questions were asked but all written reports accepted as such.

Contraceptive Reliability

There was no instance of pregnancy in any of the patients while they remained under treatment. In this respect, our results completely parallelled those of other workers and provided further evidence that the medication (if taken regularly) is for all practical purposes 100 per cent reliable in the prevention of pregnancy.

Effects on Menstruation

Like other workers, we found the medication tended to reduce the volume of menstrual flow, although this effect was not uniform and was not of very pronounced degree when present. In this series, 21 women (or 25 per cent) reported some reduction in flow but 53 (or 62 per cent) could detect no change and 3 felt that the flow was slightly increased.

Prior to medication, the majority of patients had menstruated on a regular basis, their average periodicity being 29 days. General effect of medication was to establish regular cyclic bleeding at a somewhat shorter interval, the average periodicity after institution of treatment being reduced to 27 days. There was only one instance in which cyclic bleeding failed to occur. In this patient (a 34 year old multipara) the 7th, 15th, and 16th cycles of treatment were characterized by amenorrhea, although in all other treatment cycles she bled normally.

Breakthrough Bleeding

The experience of other workers indicates that breakthrough bleeding (or spotting) occurs in a substantial number of patients in the first month or two of treatment, but that it becomes progressively less frequent as treatment progresses. In this series, bleeding or spotting was noted in only 30 (5 per cent) of the total of 604 treatment cycles (Table I). Our results confirmed the tendency of this complication to restrict itself to the early phases of treatment. In fact, 13 (that is more than one third) of the total bleeding episodes occurred in the first cycle, and 24 (i.e., more than four fifths of the total) within the initial three cycles. Bleeding rarely occurred after 3 months of treatment; and in only one case did it recur after eight months, and then only on one cycle.

Breakthrough bleeding showed only slight tendency to recur. Thus, of 19 patients who bled, 11 did so in one cycle only, 5 in 2 cycles, and only 3 in 3 cycles.

Dysmenorrhea

Since this experience was solely in order to evaluate the drug as a contraceptive, no cases of dysmenorrhea as such were included in this series. No patient complained of dysmenorrhea while on the drug.

Gastro-Intestinal Tolerance

Symptoms of gastro-intestinal intolerance tend, like breakthrough bleeding, to occur more or less exclusively in the first three months of treatment (Table I). Eleven (about 13 per cent) patients in this series manifested such symptoms. In six patients, it occurred only in the first cycle; and in one, only in the third cycle. In an additional patient, it occurred in both first and second cycles; and in three more, it occurred to some degree throughout the first three cycles. After the third month, no patient experienced any further reaction of this nature. In all instances, symptoms of intolerance were confined to slight nausea occurring predominantly during the morning hours. In no case did actual vomiting occur.

Side Reactions

At follow-up visits, all patients were questioned closely as to any symptoms experienced while receiving treatment. As might be expected, this routine led to the recording of a wide diversity of complaints, predominantly subjective, and seeming for the most part to have little or no

relationship to the program. However, among those complaints it was felt might have some relationship to therapy were: breast fullness or soreness — 4; occasional epistaxis — 2; depression — 1; and facial hirsutes — 1. The last complaint was *not* confirmed by clinical examination.

Side reactions were the ostensible reason for discontinuance of therapy in 10 patients (11 per cent), but in some instances it was felt that the alleged side-reaction was being used as a pretext for loss of enthusiasm or other extraneous reason.

A few of the patients discontinuing treatment merit brief comment. In 2 of 3 patients who gave up on account of fluid retention, there was some mild edema of the ankles. In the third patient, the edema was more generalized and of more severe degree. Following discontinuance of therapy, this patient was given a thiazide diuretic with the result that all evidence of edema disappeared within a short period of time. The patient has resumed the medication without further edema.

One patient stated her doctor diagnosed phlebitis while on the drug. She visited two other physicians, neither of whom felt that phlebitis had occurred. The patient's history is not suggestive of phlebitis; and with the lack of confirmation by two other physicians, the author feels that it is reasonable to assume that this did *not* occur.

Weight Change

No actual weighing of the patients was attempted. In retrospect, it would have been advantageous to have done this. It has been my impression that the few patients with water retention lost this after several months of continued use of the tablets.

Acceptability of Therapy

Among the 87 patients started on therapy, 22 (or 26 per cent) have subsequently discontinued. The reasons, as far as they could be gathered, are presented in Table II. With the exception of those patients who wished to become pregnant, those who abandoned treatment often did so from lack of interest and purpose rather than from any other cause. They seized upon some minor complaint to provide ostensibly valid ground for withdrawal from the program.

From the 65 patients who have continued on treatment, there have come on numerous occasions spontaneous expressions of satisfaction with the therapy. In addition to appreciating its reliability, most patients find the oral method esthetically superior to mechanical or chemical barriers. The regularity of flow and the slight diminution in menstrual blood loss are secondary advantages, which are particularly appreciated by those who were formerly irregular or suffered menorrhagia. The enthusiasm shown by the patients who are on this drug is truly remarkable.

Effects on Fertility

Among the four patients who discontinued treatment in order to become pregnant, one conceived in the first cycle after discontinuance; another in the second cycle; and the third in 8 months. The other patient has been lost to follow-up. Limited as this evidence is, the promptness with which conception occurred in three out of four patients contributes to the growing evidence that oral contraceptives do not suppress fertility beyond the period of their administration.

Summary and Conclusions

1. The contraceptive efficacy of a tablet containing norethindrone 2 mg. and mestranol 0.1 mg. has been determined by clinical trial in 87 women observed through 604 treatment cycles. Administration of one tablet daily from the fifth through the 24th day of each menstrual cycle proved completely effective in preventing pregnancy. The therapy also tended to produce greater regularity of menstruation and in some patients a slight diminution in the volume of flow.

2. Breakthrough bleeding or spotting occurred in 19 patients (22 per cent) and nausea in 11 (13 per cent). The former complication was generally readily controlled by temporary increase of dosage to two tablets daily. Both

TABLE I

Duration of Therapy and Incidence of Break-through Bleeding

Cycle	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
No. of Patients completing	85	80	71	57	54	51	35	31	28	25	23	22	12	10	8	5	3	3	1
No. of Patients with Break-through bleeding	12	9	2	1	1	1	1	1	0	0	0	0	0	0	0	0	0	0	0
No. of Patients with Nausea	10	4	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

breakthrough bleeding and nausea occurred with greatest frequency in the first three months of treatment. Neither complication was severe enough to give cause for concern or to warrant discontinuance of treatment. Intensive questioning of patients under treatment has elicited a number of complaints predominantly of subjective nature. It seems probable that most of these complaints were attributable to suggestion but isolated instances of epistaxis, depression, and facial hirsutes may have been causally related to therapy.

3. Over a period of 19 months, slightly more than one quarter of the patients started on therapy have abandoned treatment. Among 4 patients who discontinued treatment because of a desire to become pregnant, two conceived within two months of discontinuance, and the third, within nine months.

4. Patients who have remained on treatment have been virtually unanimous in their enthusiasm for this method of conception control. Both from the standpoint of reliability and aesthetic acceptability, they regard it as superior to mechanical or chemical barrier technics.

TABLE II

Reasons Offered for Discontinuing Therapy

4 Planned Pregnancy
4 Moved from area
4 Reasons ambiguous
3 Fluid retention

One each:
Dysmenorrhea
Lack of confidence
Arthritic pain worsened
Partial loss of hair
"Nervousness"
"Numbness" of arm

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41 Elm Street

Drug Evaluation by the Practitioner

The practicing physician is an important component in drug evaluation. Many excellent controlled studies have been performed by physicians, who are *not* members of a medical school or a research facility with a hospital environment. Since the majority of patients are seen in private offices and the majority of drugs are intended for these patients, it is essential that the evaluation include the practicing physician. Often the results obtained in a limited group of patients, by competent investigators in scientific institutions, cannot be carried over to the treatment of patients in field trials. Controlled studies are occasionally so limited in scope, with removal of random variables, that the final conclusions do not reflect what can be expected when the drug is used in actual practice.—Robert C. Batterman to Western Pharmacology Society, San Francisco, January 28, 1963.

Antibiotics have not produced the great sterilization that once was anticipated. Here is a careful report of one hospital's experience.

A Survey of Infections in A Community Hospital*

Robert H. Bendy, Jr., M.D./Montclair
Milton E. Landman, M.D./Bloomfield

Before the days of Semmelweiss and Lister, the incidence of sepsis in hospitals was so overwhelming that many patients could not be persuaded to enter them. With the introduction of antiseptics and aseptic technics[1] the risks were greatly reduced, especially in surgery and obstetrics. After the development of antibiotics, the prospect of bacterial elimination seemed bright. However, the ability of bacteria to acquire resistance to these drugs soon destroyed this hope. This bacterial resistance, particularly in regard to staphylococci, demanded investigation of current aseptic methods and technics, sometimes with disturbing conclusions.

Most hospitals have Committees on Infection to promote effectual asepsis. The Infection Committee of The Mountainside Hospital is publishing this report to contribute specific data on the problem.

The Mountainside Hospital occupies a modern, four-story, air-conditioned building and has a rated capacity of 430 beds. Most of the physical plant is composed of private and semi-private suites. There are four ward areas of 18 beds each. Infected cases are isolated in private rooms with individual toilet facilities in whatever area of the hospital these are available at the time.

The hospital serves Montclair and Bloomfield primarily. This includes a population of over 100,000. However, the general referral area comprises the greater part of western Essex County, providing an additional population of some 60,000. These areas represent a wide variety of social, ethnic, and religious groups. No predominant patient type characterizes the hospital population as different from similar suburban regions in this portion of the United States.

Method of Investigation

Infections were reported only when a patient was placed in isolation. This was done by the floor nurse who completed a daily infection report indicating the nature and site of infection, culture reports, and other pertinent data. These reports were then sent to the Medical Records Department where the data were entered in a monthly "Infection Log Book". Cooperation among the nursing staff was generally good. However, an occasional chart had to be examined by the committee to clarify uncertainties or omissions.

Infection Rates in Departments

On admission, infection rates (per thousand patients) varied from a high of 30 in the Department of Medicine to 4 in pediatrics. Infections developing in medical patients after admission were due mainly to such complications as decubiti. In surgery the rate was 22 on admission and 20 after admission. Abscesses and superficial skin infections accounted for the bulk of infection present on admission. Postoperative wounds dominated the picture of

*From The Mountainside Hospital, Montclair, New Jersey

surgical infections which developed after admission, comprising about 93 per cent of the cases.

The infection rate for the department of obstetrics-gynecology paralleled that of medicine and surgery: 6½ on admission and 4½ after admission.

Pediatrics and the newborn nurseries were well in line with the general average infection rates in community hospitals.[3]

Temporal Incidence

The results of this comparison of monthly infection reports are summarized in tabular form in Table 1.

TABLE 1

TEMPORAL INCIDENCE OF REPORTED INFECTIONS

Month	Present on Admission	Present after Admission (other than Post-Operative)	Post-Operative	Total
1962 March	22	0	14	35
April	18	3	2	23
May	13	2	3	18
June	20	5	11	36
July	18	1	8	27
August	19	2	8	29
September	16	1	5	22
October	23	5	7	35
November	17	2	2	21
December	23	4	4	31
1963 January	11	3	7	21
February	13	7	4	24
Totals	213	35	75	322

There is considerable variation in the number of infections reported each month. These fluctuations do not seem to be consistent with seasonal factors nor do they follow the pattern for regional epidemic illnesses. They do not correlate with the average hospital census. In fact, they are completely out of proportion to patient load.

Total monthly infections parallel closely the number of infections present on admission. The two unproportionate differences are due to the exceptional number of post-operative infections reported in March and June. There was no investigation of this situation since the entire study was retrospective.

We hope to remedy this situation in the future by constructing time-span moving averages and control charts,[2] using this year's figures as comparative norms. This will enable the committee at any time during the year to determine whether the hospital infection rate is running above or below the expected norm.

Types of Infection

Of the 13,156 patients admitted to The Mountainside Hospital from March 1, 1962 to February 28, 1963, 322 (2.5 percent) had reportable infections (i.e. meaning that they were placed in isolation). A total of 207 patients, or 64 percent, were admitted primarily because of their infections process. Thirteen patients (about 4 per cent) had infection present incidentally on admission. Thus, we had 68 per cent of infected patients who had infection on admission. The remaining 32 per cent (who developed infection in the hospital) consisted largely of postoperative wounds and other pyogenic infections.

Here is the tally by type of infections:

76 were postoperative wounds
10 had tuberculosis
27 had infectious hepatitis
32 had other communicable diseases (See Table 2)
140 had other pyogenic infections
37 were unclassified.

322

Tuberculosis—During the year, 13 cases of suspected systemic or pulmonary tuberculosis were reported to the committee on infections. Of these 13 cases, three proved to be other illnesses. Ten were signed out as tuberculosis, but only six of these had bacteriologic confirmation in the form of positive sputum cultures. The remainder were diagnosed on the basis of clinical, radiologic, and other laboratory findings.

Hepatitis—A large portion of patients admitted to the hospital with communicable diseases proved to have hepatitis. In most, this diagnosis was suggested by history and incubation period. At least six were suspected of being homologous serum jaundice because of history of multiple transfusions and appropriate incubation periods. However, the routine investigation of the involved donors by the hospital and commercial blood banks failed to reveal positive findings.

Other Communicable Diseases—Table 2 lists the 32 other communicable diseases reported for the year. In all except the case of tetanus, the disease was present on admission.

TABLE 2

COMMUNICABLE DISEASES REPORTED

Type of Disease	Number Reported
Infectious hepatitis	27
Tuberculosis	10
Aseptic meningitis	4
Bacterial meningitis	4
Viral pneumonia	2
Bacterial pneumonia	6
Epidemic parotitis	1
Gastroenteritis	2
Syphilis	1
Impetigo	3
Meningoencephalitis	4
Typhoid	2
Rubella	1
Tetanus	1
Gas gangrene	1
Total	69

Pyogenic Infections—Almost half of the infection reports received were for pyogenic diseases other than post-operative wounds. Table 3 shows that 77 per cent of these were present on admission and consisted mainly of various types of abscesses. Cellulitis and other superficial skin infections were a not too distant second. Of those pyogenic diseases incidentally present on admission (3 per cent) and those appearing after admission (20 per cent), abscesses again headed the list. However, endometritis moved into second place in this group.

TABLE 3

CLASSIFICATION OF PYOGENIC DISEASES REPORTED IN INFECTED PATIENTS
(Excl. Post-Op. Wounds)

Type of Pyogenic Disease	Reason for Adm.	Incid. Pres. On Adm.	Appeared After Adm.	Total
Abscess	49	3	8	60
Traumatic	1	0	2	3
Fistual	2	0	1	3
Cellulitis	12	0	0	12
Decubiti	4	0	2	6
Osteomyelitis	5	0	0	5
Dental	7	0	0	7
Burns	2	0	2	4
Endometritis	6	0	4	10
Pelvic inflammatory diseases	2	0	0	2
Eye	2	0	6	8
Septic arthritis	2	0	0	2
Superficial wounds	9	2	2	13
With diabetes	4	0	1	5
Totals	107	5	28	140

Post-operative Wounds—Post-operative wound infections comprised about 23 per cent of all infections reported. In general this is about eight per cent higher than the average figures found in comparable hospital infection statistics.[2,3,4,5] Sixty per cent of the patients developed wound sepsis after the initial change of dressing. This suggested that most wound infections were contracted *after* the patient had left the operating room.

Bacteriology

Table 4 lists the bacteria cultured from infected cases, excluding staphylococci. Organisms were considered sensitive if their growth on an agar plate was inhibited by discs of the appropriate antibiotic(s) for their strain (i.e. Escherichia coli and streptomycin). If no sensitivity studies were available, the organism was listed as present.

TABLE 4

ORGANISMS ISOLATED FROM INFECTED PATIENTS

	Present	Resistant	Sensitive	Total
Non Hemolytic Streptococcus	5	1	24	30
Streptococcus viridans	5	0	21	26
Proteus vulgaris	1	1	5	7
Escherichia coli	13	1	42	56
Aerobacter aerogenes	2	4	9	15
Hemolytic streptococcus	0	1	15	16
Pseudomonas aeruginosa	3	2	5	10
Mycobacterium tuberculosis	6	0	0	6
Diplococcus pneumoniae	0	0	10	10
Clostridium perfringens.	1	0	0	1
Clostridium tetani	0	0	1	1
Hemophilus influenzae	1	0	1	2

Escherichia coli was the most common organism cultured other than staphylococci. It proved to be the pathogen in multiple situations such as abscesses, post-operative wounds, fistulae, pyelonephritis, pilonidal cysts, decubiti, burns, and bacteremia. Only one proved resistant strain was isolated.

The strains of streptococci isolated were, as a whole, actually more numerous than the coliform bacillus. These organisms accounted for such infections as cellulitis, abscesses, vaginitis, dental infections, post-operative wounds, endometritis, burns, and tonsillitis.

Only ten of those organisms listed in Table 4 were found to be resistant to the usual antimicrobial therapy. Predominant in this group were Aerobacter aerogenes and Pseudomonas aeruginosa. These organisms were isolated from superficial infections and post-operative wounds.

The staphylococcus organism was present in 225 of the cultures obtained from infected patients. In 157 cases it proved to be the etiologic agent. It was concluded that the remainder, predominantly staphylococcus albus, were secondary invaders or contaminants.

Table 5 lists the infections encountered in which the staphylococcus was concluded to be the pathogenic agent. Post-operative wounds, abscesses, and superficial infections completely dominate the picture, with all other types comprising only 15 per cent of the total.

TABLE 5

TYPES OF STAPHYLOCOCCAL INFECTION

INFECTION	TOTAL
Post-operative wounds	63
Endometritis	3
Abscess	44
Superficial infection	27
Pharynx	2
Osteomyelitis	5
Decubiti	4
Burns	3
Eye	1
Dental	1
Pneumonia	4
Total	157

Staphylococci represented 83 per cent of post-operative wound infections. This is out of proportion to statistics from other reports[4,5] which list staphylococcus as the pathogen in 25 to 40 per cent of post-operative wound infections. Approximately 20 per cent of the staphylococcus aureus strains cultured were resistant to the usual gram positive antibiotics (see Table 6). This was surprisingly consistent with figures found in other reports.[2,4,5]

TABLE 6

STAPHYLOCOCCAL SENSITIVITIES

Organism	Present	Resistant	Sensitive	Total
Staphylococcus aureus	33	29	95	157
Staphylococcus albus	15	6	47	68

Summary

A year's statistics from the Committee on Infections of The Mountainside Hospital are presented. Of 13,156 patients admitted in the year, 322 (or 2½ per cent) had reportable infections. Those who had infection present on admission comprised 68 per cent of the total, while 32 per cent developed infection after admission.

Communicable diseases, post-operative wound infections, and other pyogenic infections are tabulated and analyzed. Infection rates in various hospital departments are compared and the temporal incidence of infection is noted graphically. Bacteriologic data is presented and the staphylococcal problem considered.

We are indebted to Mrs. Jane Heger for her invaluable assistance in preparing this report.

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The purpose of a medical school is to produce physicians, and the purpose of physicians is to treat sick people.

Rededication at the Bedside*

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Blairstown

This is, I understand, possibly the last convocation of the Seton Hall College of Medicine. When your next academic year begins, if the Legislature acts favorably upon the recommendation of the Governor's Committee, you will be reconvened as the New Jersey State College of Medicine and Dentistry. In North American academic usage, a convocation is ordinarily an assembly at which degrees are conferred. It is, in short, a commencement. The introductory ceremonies customarily held in medical colleges on the occasion of the first formal gathering of a new class are, however, for a different purpose and generally have no specific name. I would propose that they be called Dedication Ceremonies, since they mark the setting aside of the lives of a not inconsiderable group of individuals to a particular public service. Such a designation would also remind us of the necessity of reaffirming the purposes for which medical schools exist. In the light of the Report of the Governor's Committee, today's ceremony may be considered a dedication in another sense as well. In its legal sense, the word refers to the transfer of property to the public use in an arrangement whereby the usage of the property is restricted to the purpose for which it is dedicated. This is a purpose for the discharge of the exact letter and intent of which the administrative officers of any organization receiving public moneys must be held personally responsible.

Dedication then presupposes not only a purpose, but an unselfish one. The purpose of the practice of medicine is recognized by the State as a public one, in recognition of which it issues a license. In its simplest form, the purpose of a college of medicine is to produce medical practitioners to take care of sick people. This would seem to be so elementary as not to require comment; but, as we shall see, there are ways by which this purpose is becoming obscured nowadays, can be evaded, nullified, and even quite lost.

"When Doctors Differ." In the beginning, the medical practitioner was essentially a surgeon —the Greek *iater*. As time went on, and considerable theory was evolved about the causes of illness, there developed a distinction between manually skillful practitioners and those who relied on the implications of natural philosophy. The former were surgeons and the latter physicians. We now call all practitioners *physicians,* but these distinctions between the two original categories have deep psychologic roots. These two groups have not always enjoyed each other's company. Physicians sometimes find it difficult to get along with one another. This is because no one can be a successful physician unless he has confidence in himself. Inflated confidence often leads physicians who are devoid of humility into a position of absurd positiveness, and a positive person is often one who is merely wrong at the top of his voice. For example, your colleagues at Harvard, Cornell, and Columbia have, no doubt, been surprised to learn that a biochemist who has been selected by Rutgers to organize a medical school in New Brunswick has, after apparently mature reflection, weighed them and found them wanting. They have, he finds, blundered. Furthermore, he discovers in them a contrite mood of which they had, until then, probably been un-

*Convocation address delivered at the opening exercise of the Seton Hall College of Medicine and Dentistry on September 11, 1964.

aware. They regret, he says, having located their medical schools somewhere other than on the campuses of their respective universities. It is my understanding that Rutgers was originally planning a two-year medical school, whose students would then apply elsewhere for "finishing." It would appear that the decision of the Rutgers administration to expand its program forthwith into a most ambitious medical center may have been motivated by the expressed desire to be independent of all such outside "blundering" teaching and hospital connections.

By a curious set of circumstances, I have been associated with all three of these schools. I know of no significant body of opinion to support the amusing and positive statement that these faculties think they should have placed their medical schools directly on their university campuses, and I don't think the Dean of Rutgers does either.

Losing the Purpose of a Medical School. Do you know how the very purpose of a medical school may be lost? There are, I suggest, four such ways: (1) by losing sight of the fact that medical schools are supposed to produce practitioners; (2) by dehumanizing the patient; (3) by neglecting bedside medicine; and (4) by forgetting that patients are sick people. From the university's standpoint, a medical school can become a bottomless pit for finances, a hungry consumer of space, and a source of turmoil. Can it help a medical school to be located right on a university campus? The usual justification for this is that it improves the intellectual atmosphere of the medical students and their faculty. I have taught medicine on the university campus of Cornell and regard the possibility of improving the intellectual status of students by the inhalation of atmosphere as rather remote. The medical curriculum is demanding, and what spare time the students can command is generally spent in sports, or in socializing with the opposite sex, or, more rarely and regretfully, in emptying bottles. University campuses appear to offer no overriding advantages with regard to these particular attractions.

Definite advantages of such a situation have, however, apparently been detected in recent years by faculty members on both sides of possible medical school-university liaisons. Some of these involve practices which (like double-financing, nepotism, or conflict of interest) deserve close examination by a critical eye and extended consideration in themselves. I do not intend to imply that these interesting attractions of obvious advantage to administrators or research personnel are necessarily fraudulent. But legislators who are asked to decide how public money should be spent should be aware that there are many reasons, which have nothing to do with scholarship, why administrators may be interested in particular organizational configurations. Wheeling and dealing may be of great practical value and interest to administrators. There is a new type of entrepreneur known as a research grant operator. His services, and the time and attention devoted to this wheeling and dealing, might not contribute directly to the purpose of a medical school which purpose, we thought was clear, is really the production of physicians.

It is sometimes said that the location of a medical school on a university campus aids in the production of medical scientists. This implies that the production of medical scientists is a fundamental purpose of the medical school. To evaluate such a statement we need to know what a medical scientist is, and how one is trained. The Medical Museum of the Armed Forces Institute of Pathology's exhibit number 7 is entitled "Medical Scientists." The eminent persons concerned, who are not, of course, preserved in formalin, are Louis Braille, Jacques Cartier, Charles Darwin, Leonhard Euler, Benjamin Franklin, Johann Wolfgang von Goethe, Alexander von Humboldt, Antonj von Leeuwenhoek, Gottfried Wilhelm von Leibnitz, Guglielmo Marconi, and Alessandro Volta. In contemplating this diverse array of talent, one can be sure of only two things: (1) that all of these people thought of themselves as being something other than medical scientists; and (2) that not one was trained with such a purpose in mind. Actually, the sort of person who becomes an outstanding scientist is rarely a good clinician. He may, in fact, be a very bad one. The impersonal and querulous attitude of a professional scientist is inimical to a proper physician-patient relationship, and not infre-

quently the impersonality of a scientist-teacher becomes translated, in a medical student, into a contemptuous attitude toward patients. When the trustees of an educational institution embark upon the training of scientists, they need not only an exceptionally seaworthy administration that will not come apart at the timbers but also one experienced in the handling of small children. They also need inexhaustible supplies of money, tender loving care, and Bromo-Seltzer. Business men know that one of the quickest ways to wreck a concern is to put the scientists in charge of it. Statesmen, legislators, and politicians who are familiar with what in Britain is called The Establishment (or who may only have read C. P. Snow) have reached similar conclusions. Most university administrators learn early in their careers that most scientists are *ex officio* DPs, i.e. difficult persons; but evidently some have not discovered that a difficult person is not necessarily a scientist. The training which you medical students receive at the hands of scientists is often very puzzling. The only advice I can give you in this connection is that, if you have survived thus far, you will probably live through it; although it is true that more medical students go mad nowadays, or commit suicide, than die from diseases contracted in the line of duty. Physicians, surgeons, and scientists: there are these three, and the greatest of these are those who have common sense—precious little of which is to be found among scientists; and what is to be found is very precious, indeed. Scientists, like honesty, are important ingredients in a medical faculty; but, like honesty, they must be kept strictly under control. So much for real scientists! What about "medical scientists?" Columbia University has occasionally conferred a degree known as the "Doctor of Medical Science." Of this the *Bulletin* states: "The University confers the Med.Sc.D. degree upon a few physicians who have completed a research project in one of the basic science fields. Only staff members of the Columbia-Presbyterian Medical Center are eligible for this degree." If this process produces a scientist, in the proper sense of that word, then I can become Yogi Bear by eating Corn Flakes.

Occasionally one comes upon the term "science of medicine," but I have a book entitled "The Science of Golf." Even garbage disposal has apparently been reduced to what has been called a science. The American Medical Association has been cautious about the word science in relationship to medicine. The 1957 *Principles of Medical Ethics* (Sect. 3) state: "A Physician should practice a method of healing founded on a scientific basis." It is not said he should practice the science of medicine, or even science. What the statement means is that the art of medicine, for such it is, should be consistent with scientific knowledge.

Who then are these medical scientists that we are told a medical school of the new dispensation should produce? Generally meant are anatomists, physiologists, biochemists, and microbiologists. But these people are really biologists or chemists, and the place where biologists and chemists have always been produced is in a university. Their degrees are conferred by the combined Graduate Faculties of those universities. So it should be. Obviously there is a great deal of special interest for the biochemist or microbiologist to learn and do in a medical school, but the production of such persons is *not* a primary function of a medical school, and their role is *not* patient care. No division of Columbia University accepts candidates for the doctorate in philosophy, in pathology, or pharmacology. At Columbia, applicants are accepted for the doctorate in philosophy in the independent disciplines of anatomy, physiology, and biochemistry; but such training and degrees are under the direct jurisdiction of the Dean of the Graduate Faculties and *not* under the Dean of the Medical School. If a medical school manages to appropriate functions which properly belong to the graduate faculties of the parent university, and the training of microbiologists, let us say, passes from the hands of the graduate faculty to the medical school faculty, the academic stature of the university may become impaired and the scholarly function of the university may gradually become transformed into essentially one of maintenance and service for the medical camel which has managed to get its rhinocnesmus inside the previously relatively tranquil academic tent. In such a case, important broad aspects of the life of the university (those which, in fact,

characterize it as a university) can become lost. Knowledge of the possible effects of such a carcinoma has prevented many a wise and worthy university from acquiring a medical school. It has led others to hug themselves with delight whenever they contemplate the distance that separates them from their medical school.

The three principal ways, therefore, of losing sight of the fact that a medical school is intended to produce practitioners of medicine are: (a) to become preoccupied with the administrative ways in which a medical school can be exploited to help run a university; (b) to become primarily involved, under the guise of research, in a farrago of wheeling and dealing; and (c) to confuse the functions of the medical and graduate faculties.

By Dehumanizing the Patient. The Rutgers administration has laid down the principle that it is not the place of the medical school to teach in community hospitals because, they say, even well-equipped community hospitals do not readily lend themselves to the teaching function. Perhaps this does not really mean that the professional staffs of community hospitals are slobbering simpletons, but only that such hospitals are locations in which it is difficult to transmit information or observe natural phenomena. For the public, such a pronouncement is the equivalent to labelling the community hospital a second-class institution and dismissing its staff as pathetic nonentities. Is it proper to shake the confidence of the public in its community hospitals, where patients feel at home, even if such a derogatory attitude were justifiable? Would it not be better to concentrate on attempting to improve the community hospital? But is such disdain actually justifiable? Is it true that the community hospital is not a good place to teach? Is it true that community hospitals are inferior to medical centers? Or are they rather entirely different types of places? An analysis of these propositions seems to reveal two principal objections by those who consider community hospitals unsuitable for teaching. These are that they are (a) inconvenient for busy and important university professors to get to, and (b) they lack highly specialized facilities for those accustomed to bidding and forbidding. But we cannot set the convenience of an indolent pedagogue (who is presumably being paid to teach) above his duty. The places we most need such teaching service are those in which there is no good reason to install costly, highly specialized apparatus, the irrelevant use of which runs up the cost of medical care and is helping to put voluntary, prepaid insurance plans into the red and is partly responsible for rising premiums. If Columbia University can send teaching missions to Taiwan and to Bolivia, I am certain that any hospital in New Jersey ought to be accessible to any relatively ambulatory instructor from any medical school located anywhere in the state. Hunterdon Medical Center (which is really a community hospital) is obviously accessible to New York University Medical School, which maintains an active interest in teaching functions there. And there are at least two very good reasons why Columbia should be interested in a hospital as far away as Cooperstown, New York, and why it may seem desirable to send medical missions to out-of-the-way places. In the first place, one is mindful of one's obligation to supply service and, in the second, most educators recognize that an urban medical center does not supply a complete medical experience for students, interns, and residents. In a medical school, wholly or significantly subsidized by public funds, there is an inescapable obligation, on behalf of the interests of the community hospital. True, the most attractive internships are those in teaching hospitals. If we want to get care to the patient at the community level (and we must if we are dedicated to our function), then we *must* maintain teaching functions in the community hospitals. To take the position that the facilities in the local hospitals are to be dismissed as inadequate is not only a shocking exhibition of irresponsibility but is a step in the direction of the destruction of patient care at the local level.

What do we know of the attitude of physicians affiliated with great urban medical centers? The legislator may imagine that such doctors are enraptured by their organizations. He may assume that the urban medical center has been a result of affluent choice, like buying a Cadillac instead of a Rambler. He may suppose that if something like it could be trans-

ported to his split-level community, all the split-personality troubles of that locale would disappear. Such notions are woefully unsophisticated. The huge, depersonalized medical center is a product of its place of origin. It grows out of the ground, and its advantages and disadvantages are peculiar to that place. Its advantages could not be employed if it were lugged to the suburbs, and its disadvantages would be paradoxical there. The administration of Rutgers has stated that medical teaching in New Jersey is mediocre and it is implied that mediocrity can be done away with by building a medical center in New Brunswick. Such a center, incidentally, would have a greater proportion of beds to population than the Johns Hopkins Hospital. Now no one wants to be mediocre, but it may be questioned whether the construction of an inflated and highly specialized, research-oriented medical center is, in any sense, a specific therapeutic remedy for mediocrity.

The staffs of the great urban medical centers all deplore the dehumanization which occurs in the type of organization which becomes necessary for the handling of the large anonymous numbers of near-destitute and economically marginal persons who are attracted to the huge welfare districts of urban centers. Everyone does the best he can to keep the practice of medicine on a personal basis, but it is an uphill fight—every inch of the way—and one which should be avoided wherever possible. If the people of New Jersey occasionally need the advantages of the specialized kinds of service which such organizations are in a position to provide, they are already available without any additional load on the state budget, and the citizens of New Jersey are already being taxed in other states where they work. Such states owe New Jersey residents something in return. The people of New Jersey are in the fortunate position of not only having excellent community hospitals, but they also have easy access to a shoppers' paradise of urban medical centers in one of the greatest concentrations of medical talent in the world. It is unrealistic to consider New Jersey apart from its neighboring communities. No New Jersey resident is far removed from the multi-billion dollar investments in Philadelphia or New York, and to which they have every right of access. No medical center constructed in New Jersey can expect to equal these superb installations. Obviously, John Doe and Richard Row both know this and will continue to go to New York and Philadelphia no matter what is built in New Jersey. For the educators in New Jersey to reject the community care concept and commit themselves to an urban medical center philosophy might be a decision in favor of expensive and wasteful mediocrity. New Jersey possesses something that districts which gave rise to the urban medical centers do not: fine community hospitals with dedicated professional staffs. This is a field in which excellence is accessible. Is it wise to cast away opportunities that lie within one's reach if one has the wit to perceive them? Do we wish to treat patients as though they were merely convenient devices for transporting interesting pathologic conditions to condescending scientists? Let us not forget that the physician exists for the benefit of the patient. Patients have not been created in order to provide scientists with something interesting to work on.

By Neglecting Bedside Medicine. Another target in the Rutgers criticism of the traditional framework of medical education is bedside teaching. Emphasis in the teaching of medicine, we are told, has shifted toward the basic science laboratories. This is not a new argument. From time immemorial, advocates of various theoretical approaches to medicine have espoused doctrines which sought to deemphasize the traditional importance of bedside diagnosis. At one time, the notion that diagnosis could be greatly enhanced by examination of the urine led to the development of a special pseudoscience called uroscopy. Obviously, the examination of that humble fluid is a matter of significance; but when study of it became divorced from bedside observation, it spawned a special group of fanatics and quacks—the water-casters —who pretended to tell everything about a patient (including her chastity) by means of mystifying, but less-than-common-sense methods of inspection. So it has always been. Every new technical advance is exploited by zealots who attempt to use it to set up an *Elitephilosophic,* with its own *Schutz-Staffel;* but just as surely it is always found that one cannot neglect the patient. *There is nothing to support*

the contention that emphasis in the teaching of medicine has shifted from the bedside to the basic science laboratory. A diagnosis is never allowed to be advanced by the technician in the laboratory—it is made by the physician in charge of the patient. Laboratory work, like a jacket, completes the intellectual accoutrements of the physician; but the clinical examination is his pants. He may be able to get along without a jacket, but most people would consider him rather mad if he promenaded in his underdrawers.

By Forgetting That Patients Are Sick People. The World Health Organization takes the position that health is not a condition of mere absence of disease but a state of complete social and economic well being. This sounds pretty good and, taking his cue from it, one hospital administrator has urged his staff to embark upon a program which is essentially justified by the assumption that it contributes to the total well-being of the individual. This is an interesting and superficially laudable aim, the logic of which runs somewhat as follows: health involves total well-being; it is the physician's duty to concern himself with health; therefore, the purpose of the physician is to devote himself to the total well-being of his patients. But surely it is everyone's duty to be *concerned* with social problems. However, it is not his obligation to engage in action in areas in which he has no competence. It is unlikely that a physician (often an odious amateur outside his own field) is as competent to deal with such matters as are politicians, theologians, economists, or sociologists. That sociologists have had little enough success with such matters should serve as a warning to those who would be warned. Furthermore, if it were the function of the physician to bring about a state of total well-being, then the public could hold him professionally liable if he did not achieve this. This is an absurd conclusion which is fitting for an absurb statement of the purpose of the physician. Obviously, then, it is not the purpose of medical schools to embark upon an education pointing toward such an end. That is the business of theologians, economists, and sociologists who are trained in the seminaries and graduate schools by their own special faculties. *Deo gratias!*

A Program

Thus, when we look for the purpose of the medical school, we find it in its product—the physician. The school is successful in proportion as its graduates fulfill their function of service to the patient. Anything which tends to separate the physician from his patient, to divert him from his task, or to dehumanize the patient, or to render treatment impersonal or contemptuous should be vigorously opposed. I call upon you here, today, to dedicate yourselves to the service of your patients. Without such dedication your presence here would be meaningless. By assiduous devotion to the patient you will, in time, acquire experience; and with it, skill, even though you may have only moderate intellectual qualifications and are, like most of us, only a very ordinary person. Without such attention and devotion you will never become a physician regardless of your talents—real or imagined—or the pretensions of your training. At the very best, you may become a passable technician. Inexperience is a bad treasure, and a bad fund to those who possess it, whether in opinion or reality; leading neither to self-reliance or to contentedness it is a nurse of both timidity and audacity. Timidity betrays a lack of power, and audacity a lack of skill. There are, indeed, two things—knowledge and opinion. The one makes its possessor really to know, the other to be ignorant.

The distinguished committee appointed by the Governor has stated that "it is the unanimous opinion of leaders in medical and dental education interviewed—that the loss of the four-year medical and dental programs now offered by Seton Hall would be catastrophic." In other words, everyone who ought to know what he is talking about is of the opinion that Seton Hall is doing the job it should do. This is not to be interpreted that Seton Hall is doing the job as well as it should or could—or as gracefully as it ought to. It is the opinion of the Governor's Committee that it needs help to achieve these goals. This is not surprising. Private medical schools, unless they can command large financial resources (most of which must come nowadays from the public treasury), cannot continue to pauperize themselves to the extent that their essential functions are jeopardized.

Nevertheless, and despite the considered opinion of leaders of medicine, the same popular *arbiter elegantiarum* who has consigned his colleagues at Harvard, Cornell, and Columbia to the role of blunderers, has decided that your faculty should be fired, that you students should be disbanded, and, like so many orphaned refugees destined for foster homes, should severally be deported "across the country" and that the graduation of practitioners of medicine in this state should be suspended for the next six years! This weird suggestion was swiftly rejected by the horrified Governor's Committee, and the medical and dental professions have no intention of allowing such a sorry state of affairs to come to pass. We need you, and the people need you even more. We are determined to make sure that practitioners of medicine will be produced to meet the needs of the people at the community level. I call upon all men of good will to join in that purpose, and I recommend further that effort be devoted to the fruition of a program which has been outlined by Professor Leland McKittrick† of Harvard. This consists of four cardinal goals, as follows:

> "(1) To select, educate, and train enough highly qualified young men and women to meet the medical and paramedical needs of a rapidly growing country; to develop programs of continuing education that will bring newer advances to the sick patient as they are tested and found practical; and, in some way, to attract highly qualified physicians *away* from the medical centers *into the smaller communities* where their services are badly needed. (2) To study our medical needs in terms of the number and kinds of specialists and family physicians needed *and direct our educational program toward meeting these needs.* (3) To build and equip hospitals necessary to assure *each community* the essential modern facilities in which an enlightened professional staff can work. (4) To develop and implement a program of medical care whereby every citizen so desiring may utilize all the necessary medical and hospital resources at a cost that is within his ability to pay, whether it is all or nothing, without embarrassment and in *keeping with the human dignity to which all our people are entitled.*"

†McKittrick, L. S.: "To What Purpose?" New England Journal of Medicine, 270:827 (1963).

Pippin Hill

NEW OB-GYN DIPLOMATES IN N. J.

The American Board of Obstetrics and Gynecology announces the recent certification of the following New Jersey practitioners.

ABATE, Vincenzo, 906 Alps Rd., Wayne, New Jersey

BAMFORD, Joseph C., Jr., 500 Market St., Paterson, New Jersey

BROUGHER, David E., Maj., Patterson Army Hosp., Fort Monmouth, New Jersey

CANTOR, Eugene L., 2780 Highway 35, Hazlet, New Jersey

COLFAX, Jane A., 2343 Hamburg Turnpike, Wayne, New Jersey

DAVIS, Merle B., 187 Livingston Ave., New Brunswick, N. J.

DECONNA, Theodore J., Route 70 at East Gate, Cherry Hill, New Jersey

DIETZEL, Herbert Alban, 61 Livingston Ave., New Brunswick, New Jersey

DORIAN, Robert V., 155 W. Hobart Gap Road, Livingston, New Jersey

FLEISHER, Joseph Wolf, 946 Avenue C., Bayonne, New Jersey

IGER, Jack, 56 S. Munn Ave., East Orange, New Jersey

KERTIS, Eugene R., 435 Elmora Ave., Elizabeth, New Jersey

McGUIRE, George P. 90 Diamond Spring Rd., Denville, New Jersey

SEXTON, Robert E., River Road, Point Pleasant, New Jersey

SWARTZ, Donald Percy, 9 Donnybrooke Drive, Demarest, New Jersey

WARBASSE, Warren Whaley, 63 Green Village Road, Madison, New Jersey

ZLATNIK, Mary Ann Catherine, Olcott Lane, Bernardsville, New Jersey

STATE ACTIVITIES

Trustees' Minutes

July 19, 1964

A regular meeting of the Board of Trustees was held on July 19, 1964, at the Executive Offices. For the information of the membership, detailed minutes are on file with the secretary of each county society. A summary of the significant actions follows:

MSP Board Nominations . . . Approved the nomination of the following non-medical candidates as members of the corporation and trustees of the Board, for a three year term:

Mr. Edgar P. Eaton, Jr.—President, Carbone Corporation
Mr. Mortimer J. Fox—Vice-President, Schering Corporation

GHI Case . . . Appointed a special committee of the Board to study the majority and dissenting opinions rendered in the Group Health Insurance suit, and to consider the position and policy of the Society as the result of this decision and its effect, if any, on the Medical-Surgical plan of New Jersey:

Dr. John J. Bedrick, Chairman
Dr. Nicholas A. Bertha
Dr. Charles H. Calvin
Dr. Samuel J. Lloyd
Dr. Jerome G. Kaufman
Robert M. Backes, Consultant
Richard I. Nevin, Consultant

Physician-Hospital Guides . . . Authorized 700 reprints of the "Guides for Physician-Hospital Relationships in New Jersey," to carry out the directive of the House that a copy be sent to the president and secretary of all medical staffs, hospital administrators, and (president or chairman of) hospital lay boards in New Jersey.

Further directed that a covering note indicate that these guides are the version adopted by the 1964 House of Delegates of MSNJ, and are presented at the direction of the House so hospitals may be informed of this policy decision.

Rights of Physicians in Hospitals . . . Directed that this resolution (#3) not be distributed as directed by the 1964 House since, in the form in which it was adopted, it merely required that the resolution be received and a copy forwarded to the AMA; and the AMA House approved the recommendation of its reference committee to refer the resolution to the Council on Medical Service.

Hospital Bylaws . . . Directed that this relevant item from the annual report of the Board be distributed with the "Guides" to the president and secretary of all medical staffs, hospital administrators, and (president or chairman of) hospital lay boards—as directed by the House.

Retirement Plan for Physicians Survey . . . Directed that a separate mailing *not* be made for this purpose in carrying out the House directive; that, instead, an appropriate reply postcard be inserted in the first convenient mailing to the membership.

Academy of Medicine . . . Directed—in consequence of the House's approving a contribution to the Academy (25 per cent of the total of a $5 per capita assessment)—that a check be presented to the President of the Academy at the first session of the 1965 House.

Program on Medicine and Religion . . . Authorized that the transcript of the Special Program on Medicine and Religion be included in the "Transactions Issue" of The JOURNAL and that sufficient reprints be ordered.

Woman's Auxiliary . . . Approved as submitted the program for 1964-65; directed that the Auxiliary be reminded of the action of the 1964 House in urging that they make the Medical Student Loan Fund the number one project for the year.

Medicare Contract . . . Approved the signing of the 1964-65 contract renewal and empowered the committee to renegotiate a new contract on anesthesia payments.

AMA Delegates . . . Approved the report submitted by the New Jersey delegation to the AMA Annual Meeting in San Francisco.

Salary to Interns and Residents . . . Unanimously re-affirmed the AMA policy adopted in June 1963, namely:

> . . . as opposed to any system or program by which any part of an intern's or resident's salary is paid out of fees collected by the attending physician under any type of medical-surgical coverage.

Finance and Budget Committee . . . Named Dr. John S. Van Mater of New Brunswick (Middlesex County) to fill a vacancy on the Finance and Budget Committee.

Workmen's Compensation . . . Assigned to the Chairmen of the Workmen's Compensation Committee and of the Occupational Health Committee the recommendation adopted by the House, as follows:

> That since the Joint Legislative Workmen's Compensation Study Commission has ignored the recommendation of The Medical Society of New Jersey, the joint committees (Occupational Health and Workmen's Compensation) recommend to the Board of Trustees that further action be taken with the State Department of Labor and Industry with regard to the evaluation of disability from the viewpoint of physical impairment to be evaluated by an impartial group—as recommended by the American Medical Association and adopted by The Medical Society of New Jersey.

Special Committee Structure . . . In compliance with the directive of the House that the Board of Trustees appoint an appropriate committee to study the special committee structure, named the following:

Dr. John J. Bedrick—President-Elect, Chairman
Dr. Joseph R. Jehl—First Vice-President
Dr. John B. Fuhrmann—Chairman, Council on Public Health
Dr. Irving Klompus—Chairman, Council on Medical Services

Mental Health Legislation . . . Referred to the Council on Legislation the recommendation adopted by the House that MSNJ support legislation to modernize existing mental health laws.

Drug Addiction Problems . . . Referred to the Council on Public Relations, the Council on Legislation, and the Council on Public Health the relevant portions of the recommendation adopted by the House dealing with drug addiction problems.

Pre-Employment Physical Examinations . . . Referred to the Council on Legislation the resolution adopted by the House that MSNJ support legislation to require that pre-employment physical examinations be performed by either "freely chosen or designated physicians."

Area-Wide Planning in Hospitals . . . Referred to the Council on Legislation the resolution adopted by the House requesting MSNJ to participate in voluntary health facilities planning councils whose purposes are consonant with the objectives of the Society.

General Practitioners . . . Directed that a letter be sent to Governor Hughes strongly urging the encouragement of medical education in New Jersey in the field of general practice—to fulfill the intent of the resolution adopted by the 1964 House.

Board of Examiners . . . Approved, in the order of preference indicated, the following nominations to the State Board of Medical Examiners:

Incumbent—Edwin H. Albano, M.D., East Orange
Nominees:

1. Edwin H. Albano, M.D., East Orange
2. Francis A. Pflum, M.D., Asbury Park
3. John L. Olpp, M.D., Englewood

Discharged Committees . . . Directed that the following committees and representatives for 1963-64 be discharged as of this date, for the reasons indicated:

Disaster Control, Joint Committee with Hospital Association . . . Committee originally requested by Hospital Association; no need to continue says Hospital Association.

Medical-Legal Testimony, Special Committee on . . . Superseded by Conference Committee on Inter-Relations with Judiciary and Bar.

MSNJ-MSP Board of Trustees, Liaison Committee of . . . Committee originally requested by Medical-Surgical Plan; not active.

Osteopathic Question, Special Committee on . . . Work completed.

Utilization of Available Nurses, State Advisory Committee to Study . . . Work taken over by Permanent Committee on Nursing Education and Recruitment.

Academy of Medicine of New Jersey

LIBRARY SELECTED LIST OF RECENT ACQUISITIONS

ALLERGY

Speer, F. A., ed. The allergic child. N. Y., Hoeber, 1963.

ANATOMY, PHYSIOLOGY, EMBRYOLOGY AND HISTOLOGY

P. L. Altman and D. S. Dittmer. *and* Pitts, R. F. Physiology of the kidney and body fluids. Chicago, Year Book, 1963.

BACTERIOLOGY

Moulder, J. W. The psittacosis group as bacteria, N. Y., Wiley, 1964. (Ciba lectures in microbial chemistry).

CANCER

Pack, G. T. and Ariel, I. M., ed. Treatment of cancer and allied diseases. Vol. 4. Tumors of the breast. N. Y., Hoeber, 1960. *and* ReMine, W., Priestley, J. T. And Berkson. J. Cancer of the stomach. Philadelphia, Saunders, 1954. *and* Temkin, I. S. Industrial bladder carcinogenesis, transl. by J. J. Oliver. N. Y., Pergamon, 1963.

CARDIOVASCULAR DISORDERS

Dameshek, W. Leukemia; a monograph. 2nd ed. N. Y., Grune & Stratton, 1963 and New York Heart Assoc. Diseases of the heart and blood vessels; nomenclature. 6th ed. Boston, Little, Brown, 1964.

COMMUNICABLE DISEASES

Top, F. H. Communicable and infectious diseases; diagnosis, prevention, treatment. St. Louis, Mosby, 1964.

DENTISTRY

Hollenback, G. M. Cast restoration. St. Louis, Mosby, 1964 (Dental lecture series) *and* Index to dental periodical literature, 1963. Chicago, American Dental Assoc., 1964 *and* Monheim, L. General anesthesia in dental practice. St. Louis, Mosby, 1964 *and* Greenberg, S. N. and Greenberg, J. R. So you want to be a dentist. N. Y., Harper and Row, 1963.

GASTROENTEROLOGY

Bockus, H. L. Gastroenterology. 2nd ed. Vols. I and II. Philadelphia, Saunders, 1964.

HISTORY OF MEDICINE

The first twenty years of the University of Texas M. D. Anderson Hospital and Tumor Institute. Houston, University of Texas, 1964 *and* O'Malley, C. D. Andreas Vesalius of Brussels, 1514-1564. Berkeley, University of California, 1964.

IMMUNOLOGY

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Diabetes Detection Week 1963*

National Diabetes Detection Week is conducted each year during November. The 1963 results of this case-finding effort in New Jersey are as follows:

Screening tests were done at 70 screening centers, including 35 hospitals, 13 health departments, and at many clinical laboratories. Many physicians carried out screening in their offices. The test was a blood glucose determination. The aim was to get the sample about 1½ hours after lunch or supper, though, in fact, the time period varied enormously. A blood glucose determination of 130 or higher (by a "true glucose method") was considered suspicious. Individuals positive at this level were referred to their private physicians. In the 14,208 screening tests, 521 positive reactions were encountered and referred to their physician for diagnosis. The diagnoses as determined by the individual's private physicians are shown below:

521 positive reactors
163 were known diabetics
40 were "potential diabetics"
117 were newly discovered by this test
131 of the positive reactors were not diabetics
2 had died before end of study
66 follow-up incomplete

In Mercer County, a detailed analysis of 2,260 subjects was carried out to summarize the composition of the group screened. Here is what was found:

35 per cent were male
73 per cent were over the age of 40
38 per cent had relatives with diabetes
Total high prevalence was 86 per cent. This represented an unduplicated count of persons who are either (a) over 40, or who (b) had relatives with diabetes, or (c) both.
82 per cent were overweight, as determined by comparison with tables furnished by the Metropolitan Life Insurance Company.

Two thirds of the screenees had not eaten within the two hours previous to the test.

Diabetes Detection Week is co-sponsored annually in New Jersey by the New Jersey Diabetes Association, The Medical Society of New Jersey, the New Jersey Association of Osteopathic Physicians and Surgeons, the New Jersey Dental Society, and the New Jersey State Department of Health. The Diabetes Control Program of the State Department of Health provides materials for blood letting, facilitates the processing of blood samples, and tabulates data.

The data above represent a two and one-half fold increase in the number of individuals participating in Diabetes Detection Week over the previous year. The number of new diabetics discovered represents a four fold percentage increase over November, 1962. The screening level of 130 milligrams per cent may give a falsely positive result if the individual has eaten within one hour of the test. Note that two-thirds of those screened did so at an appropriate time postprandially. Moreover, less than one in four of the positive screenees were reported by their physicians as not diabetic. The case yield of new diabetes is twice that previously reported[1] when Dreypaks® were used by the New Jersey Detection Drive.[2] Reports were obtained from the screenee's physician for 90 per cent of all positive reactors. Follow-up in the remaining cases has been undertaken by public health nursing agencies to encourage the suspect to seek medical evaluation. Mercer County data suggest that the population screened is an older, overweight group, 38 per cent of whom have a family history of diabetes. The publicity given to Diabetes Detection Week appears, therefore, to encourage screening among a relatively high risk population.

A substantial number of previously diagnosed diabetics get screening tests during Diabetes Detection Week even though attempts are made to exclude them. In fact, such screening may be useful for this group as well, since several physicians reported diabetic patients who returned to their care after months or years of neglecting their medical program. In such cases, a positive screening test serves to re-emphasize the diagnosis for the patient and affords an opportunity to re-inforce the need for careful medical supervision.

The availability of oral hypoglycemic agents has stimulated interest in the identification of the asymptomatic diabetic. These drugs, used in conjunction with dietary regulation and weight control, provide an opportunity to treat

*This material was prepared by Kenneth I. Shine, M.D.; Arthur Krosnick, M.D.; Jack Maready, B.S.; Donald Hustis, B.S.—all of the Diabetes Control Program of the New Jersey State Department of Health in Trenton.

[1]Krosnick, A.; Dougherty, W. J.; Knowles, G. M., and Brandman, O.: J. Med. Soc., N. J. 52-496 (1955).

[2]Ellenberg, M. and Rifkin, H.: N. Y. State Journal of Medicine 61:3892 (1961).

and control hyperglycemia and glycosuria in individuals who previously would have required insulin. Clinical experience indicates that oral agents are more likely to be effective when used early in the course of diabetes, rather than after a long period of uncontrolled hyperglycemia.[3]

Summary

1. Interest in diabetes detection in New Jersey is increasing. This is reflected in a two and one half fold increase in the number of individuals screened during the 1963 Diabetes Detection Week.
2. Screening by means of a blood glucose determination, a method twice as sensitive as urine testing in identifying the asymptomatic diabetic, can be carried out efficiently and practically.
3. The number of falsely positive tests remains small, less than 1.2 per cent of the total screened. Three out of four positive screenees are diagnosed by their private physicians as new, known or potential diabetics.
4. The population screened does represent a relatively high risk group with 86 per cent over 40 years of age or related to a diabetic and 82 per cent overweight. Though control of the previous meal is difficult in such large scale screening, approximately two-thirds of those screened have eaten one and one-half to three hours prior to the test.
5. Through this activity, we discovered 117 cases of newly diagnosed diabetes. Many previously diagnosed diabetics returned to medical supervision as a result of the program. The availability of oral hypoglycemic agents and the concept of diabetes as a continuously progressive process have contributed substantially to interest in early case finding.

ACKNOWLEDGEMENT: We are pleased to recognize the contributions of Dr. Alfred Gras, President (1963) of the New Jersey Diabetes Association, and Dr. Otto Brandman, Chairman of the Committee on Education and Detection of the New Jersey Diabetes Association; also, the chairman and committee members of each of the twenty-one county component medical society's diabetes detection and education committees.

The contributions made by the Division of Laboratories, the Public Health Statistics Program, Division of Vital Statistics and Administration, Miss Diana Ricigliano, Mrs. Anne Forsthoffer of the Diabetes Control Program, New Jersey State Department of Health, and the many cooperating agencies and groups are gratefully acknowledged.

Teaching Machines in Medical Education

Dr. Arthur Krosnick, Coordinator of the Diabetes Control Program of the New Jersey Department of Health, has been awarded a U. S. Public Health Service contract to investigate the AutoTutor programmed course in diabetes control. He and his staff are comparing this type of programmed instruction with conventional training technics (printed matter, film, and lecture).

Subjects will be physicians and allied medical personnel. Although this study is specifically concerned with training in diabetes control, the question involved is applicable to all phases of education as well. You are asked to participate by volunteering to be subjects for this three hour training course. If you are interested in updating your knowledge of diabetes facilitating the development of more efficient educational methods, please notify Dr. Krosnick, either by tearing out and filling in the form below, or, if you preserve your JOURNALS intact (as you should), by sending a letter giving the information to the doctor.

- -

Please return to: Arthur Krosnick, M.D.
Coordinator Diabetes Control Program
Division Chronic Illness Control
Box 1540
Trenton, New Jersey 08625

☐ I would like to be a subject for the study comparing the AutoTutor with conventional training methods. I can best arrange to be available:

S M T W Th F S
(Circle preferred days)

9:00 A.M.-12 Noon; 1:00 P.M.-4 P.M.;

Other: .....

Preferred hospital, medical center, or other location:

.....

Name: .....

Address: .....

[3]Conn, J. W. and O'Donovan, C. J.: Detectable Asymptomatic Diabetes, American Diabetes Association New York, N. Y. (1962).

ANNOUNCEMENTS

An Approach to Psychosomatic Illness

You are invited to a unique and practical colloquium on psychosomatic illness to be held on Tuesday afternoons (2 to 4 P.M.), at the Ancora State Hospital at Hammonton, N. J. For more details, including information about how to get to Ancora, write to Dr. Renate M. Schaeffer, Ancora State Hospital, Hammonton, N. J. On October 6, the program will be devoted to anxiety, panic, and shock reactions; on October 13, to the psychosomatics of cardiovascular disease; on October 20, to the gastro-intestinal tract viewed as a sounding board for the emotions; and on October 27, to recent developments in psychosomatics.

Diabetes Symposium

The New Jersey Diabetes Association, in cooperation with the State Department of Health, will present a Symposium on "Peripheral Complications of Diabetes Mellitus" Wednesday, October 21, 1964, 2 to 5 p.m. at the Newark City Hospital, Bergen Street, Newark.

The following speakers will discuss the indicated topics:

Max Ellenberg, M.D.—Associate Physician at New York's Mt. Sinai Hospital: "Neuropathy in Diabetes"
Leon G. Smith, M.D.—Director of Medical Education at St. Michael's Hospital, Newark: "Diabetes Infection: The Host and The Organism"
Kermit Pines, M.D.—Associate Professor of Clinical Medicine at Columbia University: "Lipid Metabolism and Vascular Disease In The Diabetic"

For more details, write to Diabetes Program, Health Department, Box 1540, Trenton, 25, N. J.

Heart Association Meets in Jersey

You can now register for the scientific sessions of the American Heart Association, October 23, 24, and 25 in Atlantic City. A star-studded faculty provides down-to-earth practical pointers to clinicians. For details, write to New Jersey Heart Association, 1500 Kings Highway, Cherry Hill, New Jersey.

Medical Conference on Sports

The Sixth Conference on the Medical Aspects of Sports, sponsored by the American Medical Association Committee on Sports, will be at Miami Beach, at the Deauville Hotel on November 29, 1964. The Conference will be held in conjunction with the Clinical Convention of the American Medical Association. This conference will cover a wide range of subjects. Included will be papers, panels, and discussions relating to training and conditioning, prevention and treatment of injuries, physiology of sports participation, and other subjects. If you would like to receive announcements concerning the Conference, address the Committee on the Medical Aspects of Sports, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

New Surgical Diplomates

At the June 1964 examinations of the American Board of Surgery, two residents of our state were certified: Dr. Robert W. Sherry of Nutley and Dr. Elias Tsoukas of Allendane.

Publications on Genetics

Now available to you is a bibliographic listing of publications on birth defects, chromosomes, genetics, arthritis, and some of the basic sciences. Information on The National Foundation-March of Dimes Professional Film Library and on publications, films, and exhibits for the lay public is included. A tear-off order form is appended.

Your copy may be obtained, free of charge from:

The Medical Department
The National Foundation-March of Dimes
800 Second Avenue
New York, New York 10017

Heart Disease Pamphlet

A short, readable pamphlet is now available in quantity to physicians interested in educating patients about smoking and heart disease. Called *Smoking and Heart Disease*, this 12 page brochure is obtainable from the American Heart Association at 44 East 23 Street, New York 10010—which sponsors the publication.

OBITUARIES

Dr. Milton Borrone

On July 10, 1964, Dr. Milton Borrone, one of the State's leading otologists, died in Jersey City. Dr. Borrone was born in Hoboken in 1895. He received his medical degree at George Washington in 1926, and did graduate work in largyngology with Chevalier Jackson. He was senior otologist to the Jersey City schools and professor of otology at Seton Hall. Dr. Borrone was chief of otology at the Jersey City Medical Center.

Dr. Harry M. Gochman

A heart attack on June 17 took the life of Dr. Harry Mitchell Gochman, one of Passaic County's senior pediatricians. Born in Europe in 1895, he came to New York City in childhood and received his medical degree at Bellevue in 1920. He crossed the Hudson to serve an internship at the St. Joseph Hospital in Paterson, and remained in Passaic County for the rest of his professional life. For twelve years he served on Paterson's Board of Health, where he pioneered in child hygiene activities. He was affiliated with the pediatric services of several hospitals in the Passaic County area and was associate pediatrician at St. Joseph's.

Dr. Jacob L. Mathesheimer

At the grand age of 80, Dr. Jacob L. Mathesheimer died at the Jersey City Medical Center on August 28, 1964. A Golden Merit Award laureat of our Society, he was one of the founders of the Greenville Hospital in Jersey City, and a pioneer in New Jersey proctology. Born in New York City, he came to Hudson County in infancy and there he lived for the rest of his long and useful life. His M.D. degree from the University of Maryland was given in 1907. He interned at Lenox Hill Hospital in New York and did graduate work in surgery in Berlin. He served in the medical corps of the Army of the United States during the first World War. For a quarter of a century, he was on the faculty of New York's Polyclinic Hospital. Dr. Mathesheimer established the proctology service at Greenville Hospital and served the people of Hudson County for fifty years.

Dr. Paul B. Means

Dr. Paul B. Means, until recently on the staff of our Trenton State Hospital, died at Johns Hopkins in Baltimore on August 10, 1964. Born in 1892, he received his M.D. at the Jefferson Medical College in 1914. After finishing his internship, he accepted a commission in the Medical Corps of the Army. On being mustered out of military service, he did general practice in Trenton. Becoming increasingly interested in psychiatry, he entered the State Service, and worked in various capacities, mostly at the Trenton State Hospital. Only this spring, Dr. Means received the Golden Merit Award of our State Society. He retired five years ago, but retained his membership in the Mercer County Medical Society.

Dr. Louis A. Pyle

Born in 1892, Dr. Louis A. Pyle died at the Jersey City Medical Center on June 13, 1964. Dr. Pyle was a past-president of the Hudson County Medical Society. He received his M.D. at the University of Pennsylvania in 1916, and interned at the Christ Hospital in Jersey City. He was a general surgeon and chief of that department at Jersey City's Fairmount Hospital. He was also medical director of the Colonial Life Insurance Company, and was cited by President Truman for extraordinary medical service to our State's draft boards during World War II.

Dr. E. Warren Rodman

Dr. Ellwood Warren Rodman, past-president of the Burlington County Medical Society, died on August 26, at the age of 63. Dr. Rodman won his M.D. at the University of Pennsylvania in 1924. He saw active duty with the medical corps of the Army of the United States during World War II. He was active in Masonic, American Legion, and civic affairs and had several tours of duty with the Beverly (N. J.) Board of Health. Dr. Rodman served the people of South Jersey as a general practitioner for almost 35 years.

BOOK REVIEWS

Protein Metabolism. Edited by F. Gross. Germany, 1962, Springer-Verlag. Pp. 521.

The broad nature of this international symposium can be gained by listing a few of the categories under discussion. These include action of hormones at the cellular level; factors influencing protein metabolism in the organism; evaluation and mode of action of anabolic steroids; protein metabolism in human pathological states, and the effects of anabolic agents in man. A competent review of all these subjects is virtually impossible in the space allotted. Only the influence of these anabolic agents as they refer to gastroenterology will be discussed.

Liver cirrhosis due to the nutritional deficiency prevalent in India is completely reversible if treated at an early age, despite the development of fibrosis. But this condition is clinically very much different than the cirrhosis found in this country and usually associated with excessive alcoholic intake. Total protein and enzymes of the liver are most labile, those of the brain most resistant.

Large doses of synthetic anabolic steroids (40 milligrams per day for one month) were found to interfere with bilirubin conjugation and transport from the liver cell into the bile. A significant paper refuted the effect of anabolic steroids on osteopenia (osteoporosis). The administration of Durabolin® in doses of 25 to 50 milligrams per week from one to two years had no objective therapeutic effect.

One of the interesting papers discussed the permanent effects of undernutrition in fetal life on the adult organism. On the other hand, overnutrition accelerates bone age in animals and in man, and consequently is to be deplored during adolescence.

HGH — human growth hormone — in man causes retention of N,P,K, hyperglycemia, and fat mobilization, but the relation between these metabolic changes and the increase in growth cannot be readily explained.

The measurement of anabolic and androgenic activity by determining the weight levels of the levator ani muscle and seminal vesicles in castrated rats was a significant advance in standardization of techniques.

A. I. Friedman, M.D.

Psychological Development in Health and Disease. By George L. Engel, M.D. Philadelphia, 1962, Saunders. Pp. 435.

Dr. Engel is both an internist and a psychiatrist. He attempts here to light up the physician's need for understanding psychologic development. The first half of this book is a rather traditional and somewhat pedestrian account of psychological development. It includes a discussion of instincts, homeostasis, the stages of psychosexual development, and the psychoanalytic theory of behavior. Much brisker is the second half, which develops the concept of disease as a natural phenomenon—a failure to adapt or adjust. Presented here is a bold and broad concept of man as a creature in constant relationships to his community, his fellows, and the natural environment around him. Dr. Engel expects that "the next great advance in medicine will evolve through the study of the brain and behavior." The author does not think of behavior as a kind of cerebral secretion but he warns against any dichotomizing between brain and human behavior. Dr. Engel does not include case histories or vignettes (in the Introduction he explains why) so that some of the material remains at the abstract level for want of a concrete "for instance" to tie it to. But the book as a whole is thought-stimulating and will reward careful study.

Abraham Leff, M.D.

Pathophysiology and Treatment of Body Fluid Disturbances. By Hans G. Keitel, M.D. New York, 1962, Appleton-Century-Crofts. Pp. 310. ($6.95)

Dr. Keitel provides a complete review of the pathophysiology of body fluids with good discussion of the cations and anions. He empha-

sizes particularly the difference in the fluid imbalance of various individuals according to weight and age. His discussion of sodium and potassium is fine.

The section on the diagnosis of fluid imbalance is not quite as adequate as one might wish. The section on principles of treatment is quite complete. Probably the best section is the one on prevention and treatment of fluid balance disorders in specific diseases. Interesting case reports are given. The chapter on disturbances of fluids is also excellent. There are appendices on the catabolism of muscle tissue, the ingestion of high protein content milk, and the maximal water diuresis test. There is a voluminous and excellent table of references.

This volume provides an exhaustive and accurate picture of the pathophysiology of body fluid disturbances. It will be used more as a reference work than as a simple guide. Students would probably find the information in this volume a little too much to assimilate. I recommend the book for advanced students of fluid disturbances. William A. Jarrett, M.D.

Immunoassay of Hormones. Edited by G. E. W. Wolstenholme, M.B. and M. P. Cameron, M.A. Illustrated. Boston, Little, Brown & Co., 1962. Pp. 419. ($10.75)

This excellent and critical compilation of laboratory data deals with the detection and assay of peptidic and protein hormones by immunochemical means. The products considered here are the growth hormones, insulin, glucagon, thyrotropin, corticotropin (ACTH), prolactin, and the gonadotropins.

The key problems in the immunochemical assay of hormones are the production of a specific antiserum and the homogeneity of the antigen-antibody system. These problems are discussed by 28 scientists and clinicians actively engaged in research along these lines. In addition, there are excellent discussions of the available methods involved in these assays: agar gel diffusion, immunoelectrophoresis, and quantitative precipitin tests. The usefulness of these assay procedures in clinical medicine is documented by clinical data.

This book is provided with a good bibliography and is adequately indexed. This text should find wide acceptance among endocrinologists, immunologists, biochemists, and physicians interested in these technics.

Harold M. Bates, Ph.D.

A History of Wine as Therapy. By Salvatore P. Lucia, M.D. Philadelphia, 1963, Lippincott. Pp. 234. Illustrated.

The use of wine in the treatment of many and varied pathologic problems is carefully traced historically over a period of about four thousand years, beginning with the earliest records available, including the Mesopotamian civilization. The author reveals much empirical data recorded over these past many centuries, often intermixed with superstitions, traditions, and folklore connected with the therapeutic use of wines. Many types have been used either specifically or as a component of some multiingredient concoction for special therapy. To compare these data with modern scientific methods of measurement and assessment has been an objective in this book. Recent studies on the effect of wines on cholesterol metabolism, gout, and hippuric acid excretion have been reported. Vitamin content and bactericidal properties have been described. The modern reports make an interesting comparison with the empiric data in regard to possible scientific explanations of some of the ancient findings. However, much more research is needed to make the correlation more valid. The chronologic index of the use of wine in therapy is particularly good from the standpoint of medical history.

George B. Sharbaugh, M.D.

Smoking and the Public Interest. By Ruth Brecher and others. Mt. Vernon, New York, 1963, Consumers Union. Soft binding. Pp. 223. ($1.50)

In 1492 Columbus brought the tobacco leaf to Spain. The use of tobacco in various forms spread like "wide fire," and its continued use has been controversial. The smoking habit has been denounced on moral and physical grounds for centuries. The deleterious effects of tobacco

are associated not only with lung cancer, but are known to aggravate such conditions as peptic ulcer, heart disease, vascular disease, and other disabling lung conditions.

The "Consumers Union report on smoking and the public interest" is a praiseworthy effort in attempting to "bring this murky picture into some kind of focus so that understanding may replace bafflement and out of understanding may come some informed action to deal with what is already a major health problem and is in fact becoming a social one."

The book is a joint effort, and is divided into four parts. The first part deals with the medical evidence of diseases associated with the use of tobacco. This information has been culled from accurate scientific sources. The second part discusses the public relations of the tobacco companies. The third part deals with the advertising approach of the industries; and part four, the last and most important, delineates the points of approach to this most serious and most overwhelming matter.

The editors suggest the prohibition of sales to minors; cigarette taxation proportional to nicotine and tar content; regulation of cigarette labeling and advertising, both of which should stress the hazards of smoking; an antismoking advertising campaign; an educational program for students and adults; and a system of clinics and other therapeutic aids to help individuals stop smoking. All of these would act as "a network of reminders" to discourage the habit.

This unusually important publication provides, for the first time all in one place, a thorough review of the medical evidence relating cigarette smoking to disease, a report on industry activities in connection with the problem, and a survey of possible steps in a program to deal with it.

Jacob Schmukler, M.D.

Books Received

Medical books are being released faster than this JOURNAL *can publish reviews. That our readers may be kept informed, we will hereafter release periodically a list of new books brought to our attention. Formal full-length reviews will be published as space becomes available. We still have some reviews of 1962 books not yet published and are releasing these reviews as rapidly as we can.*

Business Management of a Medical Practice. By Bernard D. Hirsh, LL.B. St. Louis, 1964, Mosby. ($7.75). A compendium of facts, forms, and advice on the legal and economic side of operating a physician's office.

How to Stop Smoking. By Herbert Brean. Eighth Printing. New York, 1964, Pocket Books. Paperback. ($0.35). If you don't give up smoking after following Mr. Brean's suggestions, Pocket Books, Inc. will refund your 35 cents.

The Cured Alcoholic. By Arthur Cain, Ph.D. New York, 1964, John Day. ($4.95). Suggests that cured alcoholics can become normal social drinkers.

The Road to H. By Isidor Chein, Ph.D. *et al.* New York, 1964, Basic Books. ($12.50). A detailed sociologic study of narcotic addiction.

Law and Psychiatry: Cold War or Entente Cordiale. By Sheldon Glueck, LL.B. Baltimore, 1962, John Hopkins University Press. ($4.59). A new formula for appraising criminal responsibility.

Psychological Development in Health and Disease. By George L. Engel, M.D. Philadelphia, 1962, W. B. Saunders Company. ($7.50). A new effort to weld together the development of mind and body.

Modern Treatment of Pulmonary and Liver Disease. Edited by Carl Muschenheim, M.D. and Richard Capps, M.D. New York, 1964, Hoeber. This is one of the series of six "modern treatment" paperbacks available on an annual ($16.00 a year) subscription basis only.

Infectious Diseases of Children. S. Krugman, M.D. and Robert Ward, M.D. St. Louis, 1964, Mosby. ($15.75). Pp. 423. A new edition of a text which, in 6 years, has become one of the standard works in pediatrics.

ABSTRACTS ON TUBERCULOSIS AND OTHER RESPIRATORY DISEASES. ISSUED BY THE NATIONAL TUBERCULOSIS ASSOCIATION

OCTOBER, 1964 • VOL. XXXVII, NO. 8

CLINIC FOR PREVENTING CHRONIC BRONCHITIS

An experimental clinic was set up in an attempt to control such factors as respiratory irritation and infection in the early stages of chronic bronchitis. The experiment demonstrated that such a preventive clinic can be operated satisfactorily.

In the management of patients with chronic bronchitis all practicable measures to reduce respiratory irritation and infection are usually undertaken, but these measures are seldom applied until irreversible disease is well advanced.

In an attempt to stop or slow down the progress of the condition by applying such measures to those in the earliest stages of chronic bronchitis, an experimental clinic was established four years ago at a health centre in Willesden. The clinic had the active support of a local hospital, a chest clinic, the public health service, and a number of general practitioners.

The principal aims of the clinic were to (1) reduce irritation of the respiratory tract by helping patients to stop smoking and by teaching them practical steps to reduce the damage done by air pollution; (2) combat infection by the use of influenza vaccine and antibiotics; and (3) teach them to improve their breathing by daily exercises.

The clinic differed in two important respects from the accepted pattern of general-practitioner consulation or hospital out-patient attendance. Changing of habits was considered more important than dispensing of drugs, and patients were not necessarily ill or disabled.

The most suitable time for the clinic was found to be from 7 to 9 p.m. The patients were seen in groups of 10 to 20 rather than individually. This not only involved each patient for two hours each evening but helped to disguise the educative function of the clinic by creating a social atmosphere.

On the first evening there was an introductory talk on the symptoms, natural history, and what is known of the etiology of chronic bronchitis. Breathing exercises were also started. A questionnaire on respiratory symptoms was completed and forced expiratory volume (FEV_1) was measured.

At subsequent sessions time was alloted for physiotherapy in order to mobilize the chest and shoulders, to encourage abdominal breathing, and to improve posture and teach relaxation.

Those who came regularly to the course of six sessions were given 12 tablets of tetracycline on the last evening with detailed instructions on how to take them at the onset of a chest infection. They were told to see their own doctor if the infection had not been controlled before the tablets ran out and to replenish their supply for use in a subsequent attack.

The known facts about smoking and bronchitis, lung cancer, and other diseases were explained by means of talks and films and by demonstrating pathological specimens. Ex-smokers in the group were witnesses that many people have stopped smoking.

Patients who completed the course were invited to return whenever they liked and for at least one evening each autumn for a "refresher" course.

C. H. Wood, M.B., *and* Susan H. Meadows; *British Medical Journal,* November 2, 1963.

During the first two winters 165 men attended the clinic. Of these, 56 were referred by their personal physicians, 54 by industrial medical officers, 17 from a mass X-ray unit, 12 from a chest clinic, and the remainder from a variety of sources. The patient's physician was always consulted.

Most of the patients said that they had had at least one chest illness, usually called bronchitis, which had kept them from work in the past three years. All but 30 said they had either persistent cough or phlegm. Most of the 30 had had recurrent chest illnesses associated with wheezing respiration.

Attendance Analyzed

Of the 128 patients who attended the clinic at least twice, 91 returned specimens of early morning sputum; 34 of these produced more than 5 milliliters of sputum and 20 produced mucopurulent or purulent sputum. Despite the attempt to concentrate on early cases who were not disabled, there were 18 men who said they sometimes had to stop for breath while walking at their normal pace on the level. A quarter of those referred to the clinic were non- or ex-smokers.

The demonstration of the fact that a preventive clinic of this nature can be run is important. Many had been advised only to come and see what it was like. It was explained to them that they would have to attend regularly for four more sessions if they were to obtain any benefit. Of the 128 who attended a second time, only 15 failed to attend four sessions. The lapse rate was slightly greater among the younger patients and among heavy smokers.

The extent to which advice was followed on specific points was determined at the end of two years to be:

Breathing Exercises. Among 109 patients, 31 (28 per cent) said that they did their exercises regularly and a further 57 (52 per cent) said they were doing them during their normal activities.

Tetracycline. Of the 106 who had been given tetracycline tablets, 46 reported having the type of episodes for which they had been told to take the tablets. Of these, 37 (80 per cent) took them on one or more occasions, a further two took other appropriate measures on their doctor's advice, and seven failed to take them.

"Smog" Bottle. These were wick-type bottles containing a mixture of ammonia and ethyl alcohol that would neutralize the acidity atmosphere in a room in times of fog. However, there were so few occasions when the bottles might have been used that no assessment of their efficacy was possible.

Smoking. Of the 77 smokers, 28 (36 per cent) had stopped smoking; 24 (31 per cent) were smoking less; 24 (31 per cent) were smoking the same, and 1 (1 per cent) had increased. One ex-smoker had started again.

Influenza Vaccination. Approximately 40 patients, a high proportion of those attending before Christmas each year, were given anti-influenza vaccine. No attempt was made to assess the value of this measure by itself.

Patients Interested

The most encouraging aspect of the work of the clinic was the interest shown by those who attended regularly. It became apparent that many with established bronchitis understand the progressive nature of their disease and are distressed about it and well aware of the uselessness of imbibing bottles of cough medicine. The presence at the clinic of a few established cases, together with pathological specimens taken from advanced cases, helped to emphasize the progressive nature of the disease to those in the early stages. However, the presence of too many established cases would probably deter the younger and earlier patients from coming.

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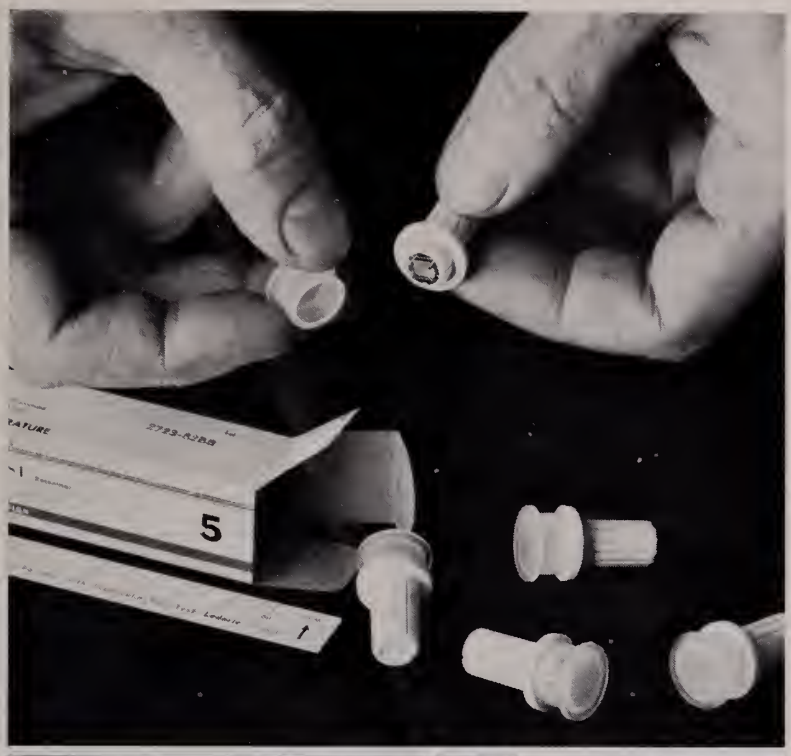
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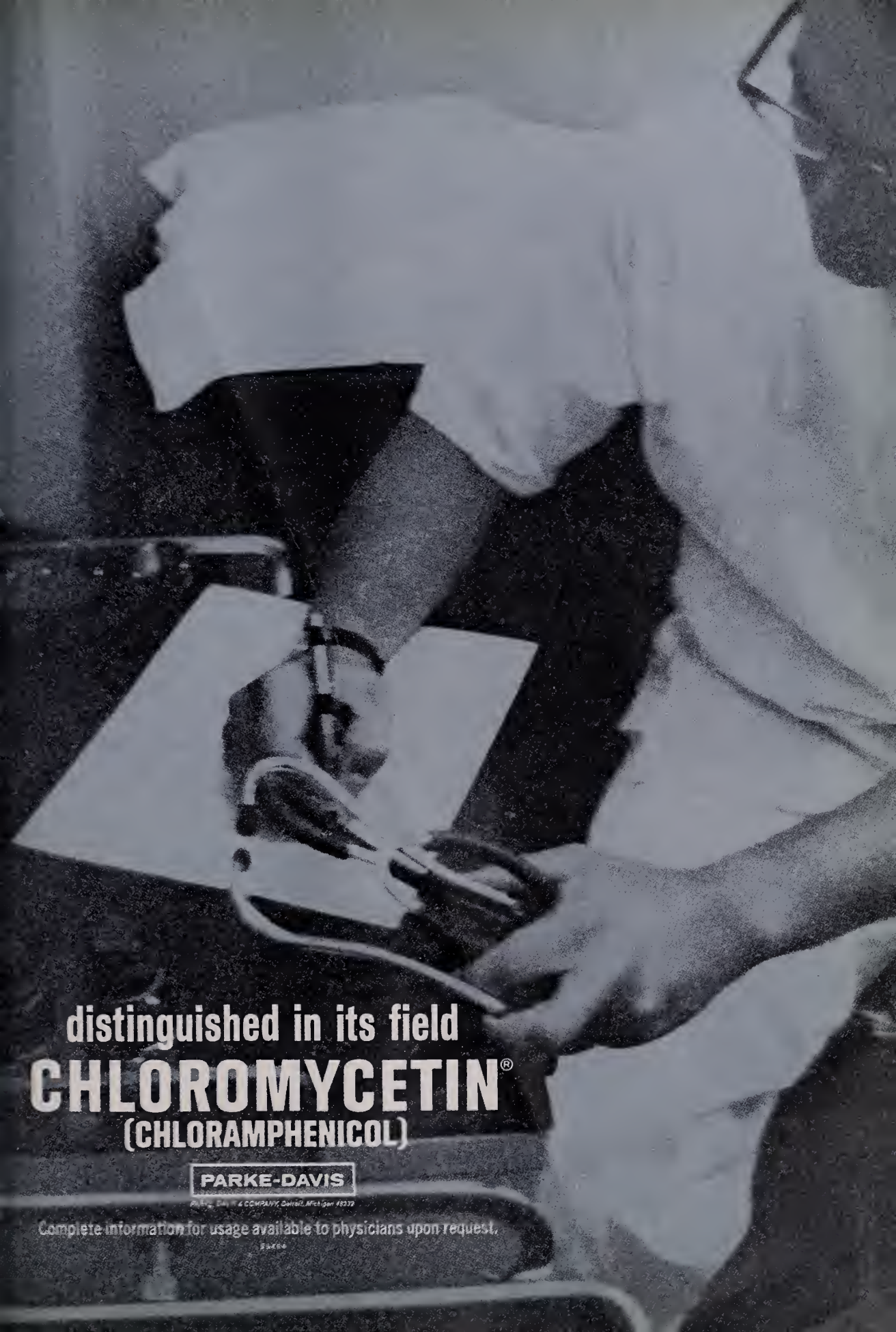
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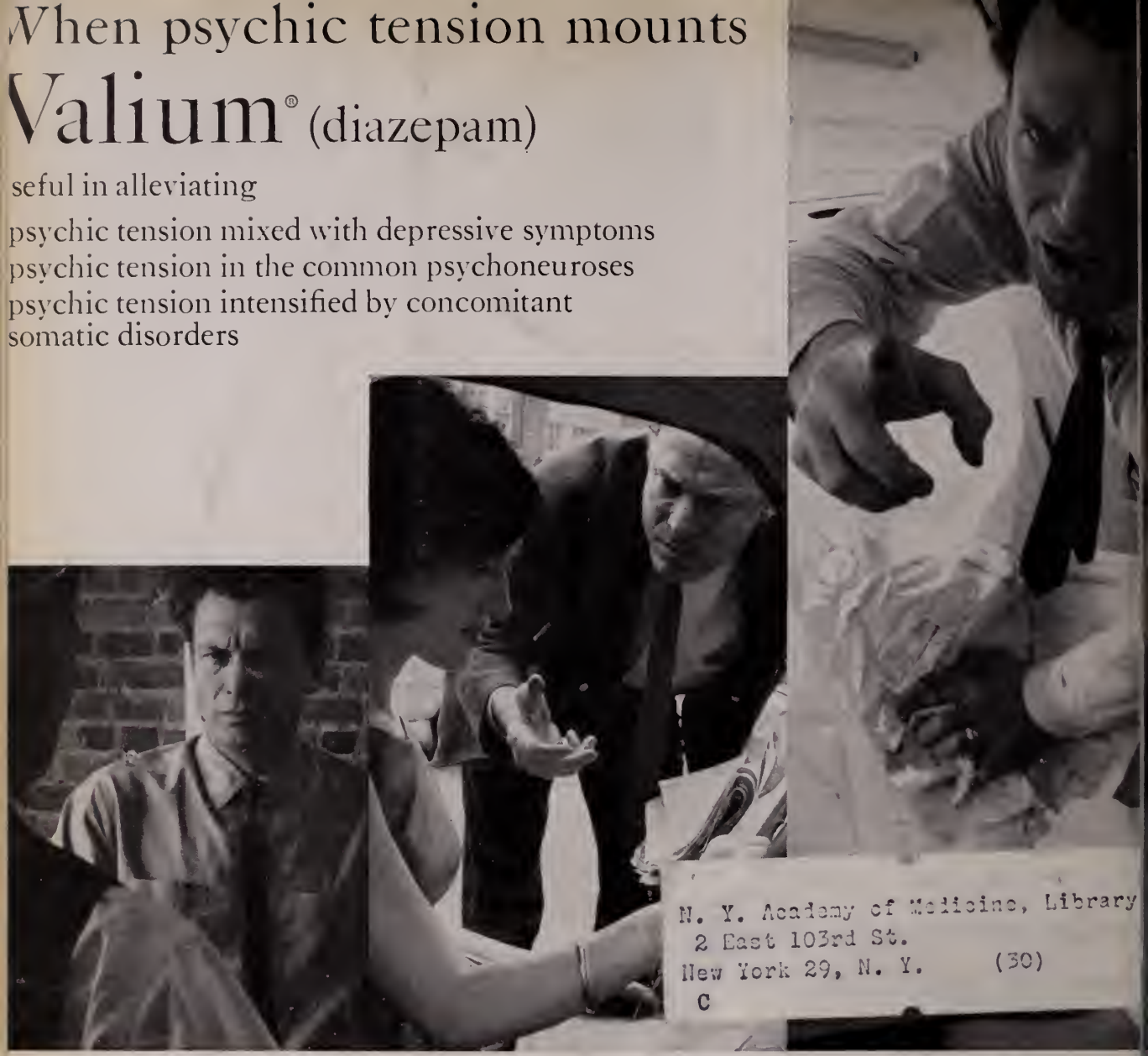

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recautions: In elderly or debilitated patients, it is important to limit the osage to the smallest effective amount to preclude the development of ataxia or oversedation (not more than 1 mg, 1 or 2 times daily initially, be increased gradually as needed and tolerated). As is true of all NS-acting drugs, until the correct maintenance dosage is established, atients receiving Valium (diazepam) should be advised against pos-bly hazardous procedures requiring complete mental alertness or (diazepam) therapy is not recommended. In general, the concurrent administration of Valium (diazepam) and other psychotropic agents is not recommended. If such combination therapy is used, careful consideration should be given to the pharmacology of the agents to be employed with Valium (diazepam)—particularly with known compounds which may potentiate the action of Valium (diazepam), such as phenothiazines, barbiturates, MAO inhibitors and other antidepressants.

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Side effects: In clinical use, fatigue, drowsiness and ataxia have been reported; in most instances these are dose-related and may be avoided by proper dosage adjustment. Mild nausea and dizziness may occur on occasion. As with any new agent, when it is administered for protracted periods of time, periodic blood counts and liver function tests are advisable. Abrupt cessation after prolonged overdosage may, in some patients, produce withdrawal symptoms (*e.g.*, convulsions, tremor, abdominal and muscle cramps, vomiting, sweating) similar to those seen with barbiturates, meprobamate and Librium® (chlordiazepoxide HCl). Changes in EEG patterns have been observed in patients during and after Valium (diazepam) treatment.

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references:* Boyd, E. M., and Ronan, A. K.: Am. J. Physiol., 135:383, 1942.

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* AMA Council on Foods and Nutrition: The Regulation of Dietary Fat, *JAMA* 181:411-423 (August 4, 1962).
AMA Council on Foods and Nutrition: Composition of Certain Margarines, *JAMA* 179:719 (March 3, 1962).

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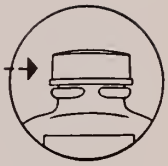
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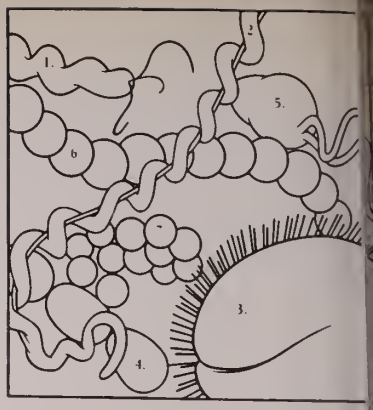
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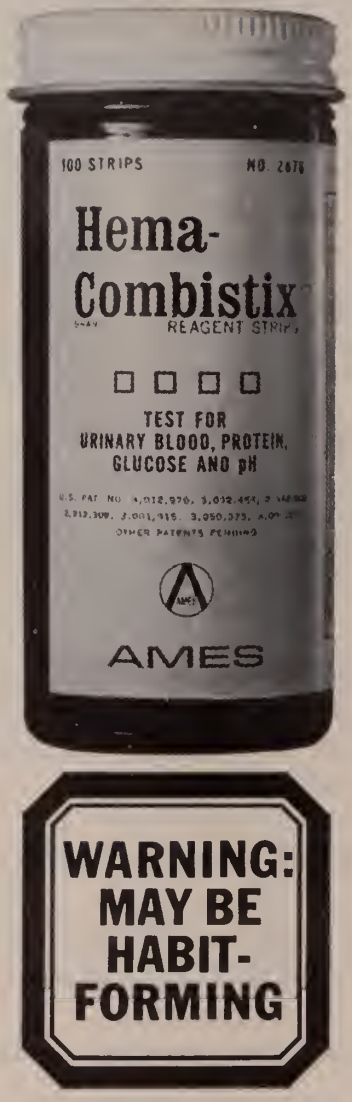
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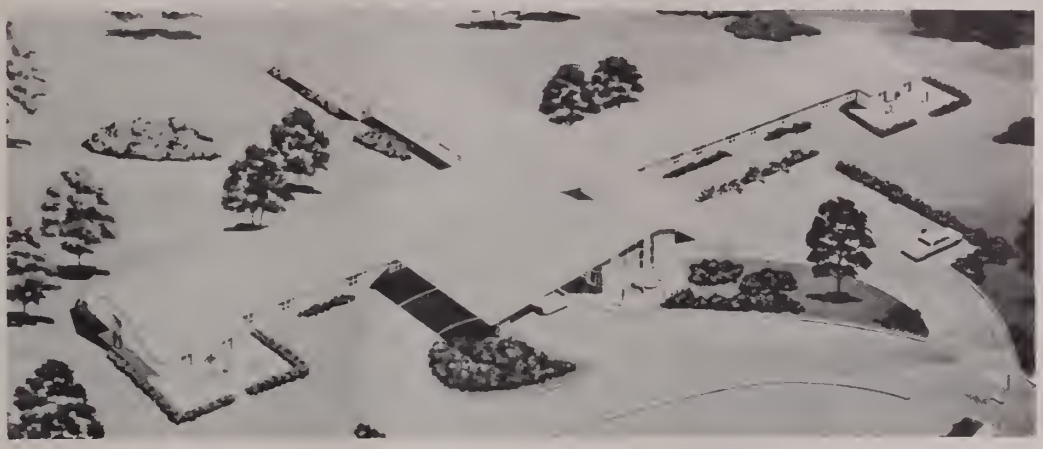


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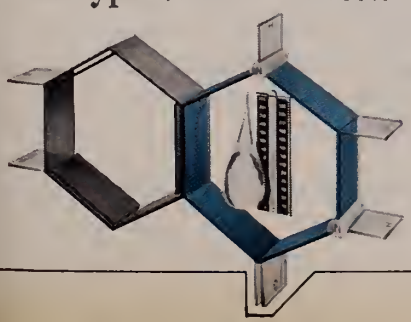
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INDICATED in hypertension with or without edema, and in all types of edema involving salt retention. May be helpful in some cases of lymphedema, idiopathic edema and edema due to venous obstruction.

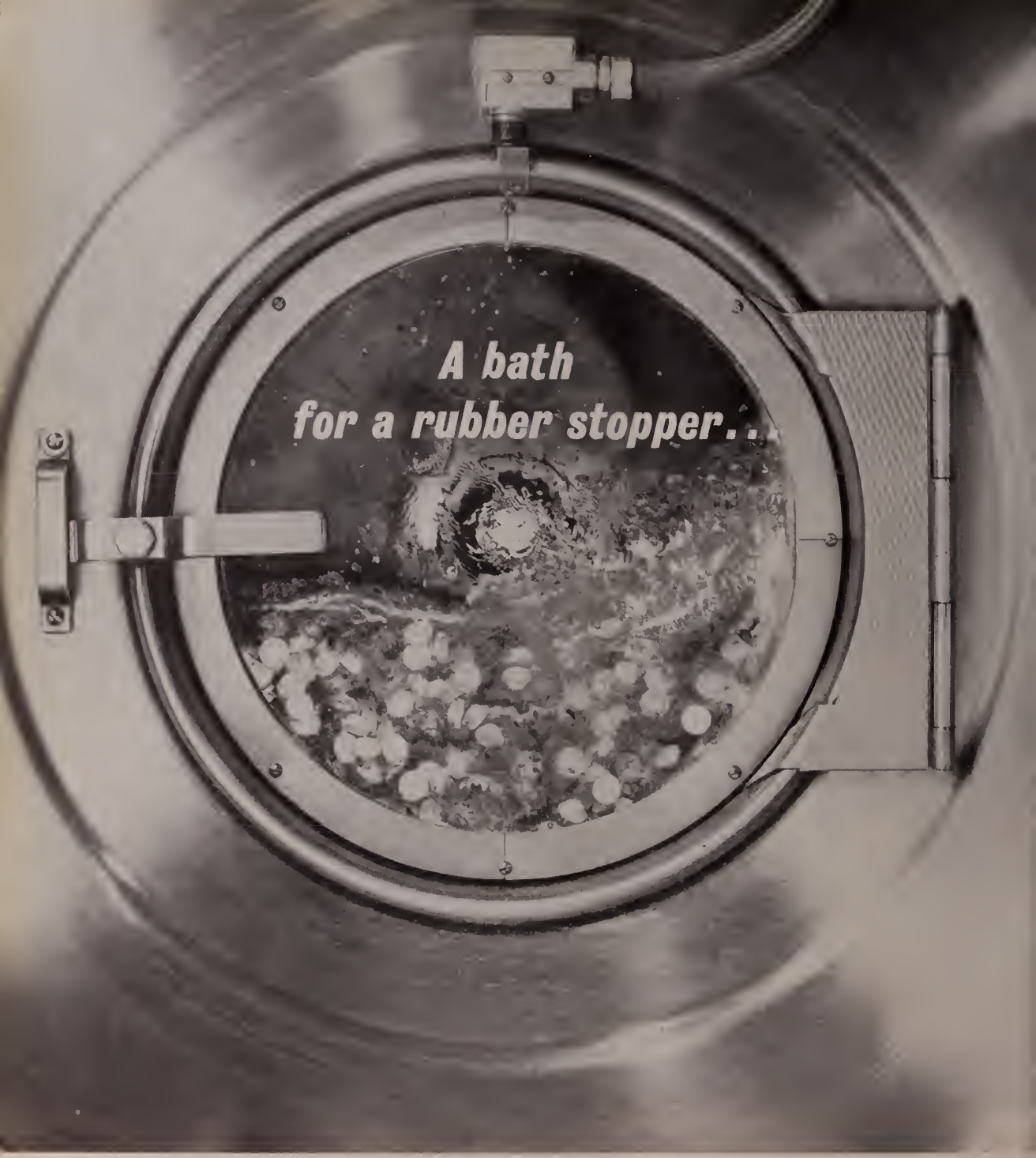
SIDE EFFECTS: Skin rash (rare), gastrointestinal disturbances, weakness and dizziness, seldom so severe that drug should be stopped. Generally, the adverse effects sometimes associated with the thiazide diuretics are possible. Pre-existing electrolyte abnormalities may be aggravated.

CONTRAINDICATION: Anuria.

1. Steigmann, F., and Griffin, R.: Evaluation of Quinethazone, a New Diuretic. J. Amer. Geriat. Soc. 11:945 (Oct.) 1963.

2. Schwartz, M.: Office Evaluation of a New Diuretic in Patients with Hypertensive Diseases. Scientific Exhibit Presented at the Clinical Meeting of the American Medical Association, Los Angeles, California, Nov. 25-28, 1962.

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and it's not a once-over-lightly one, either. All rubber stoppers used in Lilly ampoules are scrupulously cleaned with a detergent and hot deionized water in a special washing machine like the one pictured above. This removes any foreign matter adhering to them. Then the stoppers are autoclaved at 120° to 121°C. for one hour. They are now clean, sterile, and ready for use. In case the stoppers are not used within seventy-two hours, they are returned for resterilization. □ This meticulous process is only one of the many safeguards to insure the quality of the finished product and to protect the ultimate user.

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EDITORIALS

The Parnate Lesson

Last February, the Food and Drug Administration recommended that Parnate® be withdrawn because serious side effects were reported in some cases. The manufacturer (Smith, Kline and French) complied—under protest. Here was an honest difference of opinion. Did the advantages of the drug outweigh the hazards? And in the face of such difference of opinion, was there any appeal to impartial experts? Or would the rulings of a bureaucracy be allowed to dispose of the matter without appeal? What happened was that the manufacturer continued to explore, with FDA, the possibilities of Parnate® being made available again since it was certainly a valuable drug.

Finally, in July, Parnate® was allowed to reenter the market under new rules.

Most of us will approve the reinstatement of Parnate® as a step which preserves for the doctor his traditional right to prescribe medication he believes indicated for his patients. One factor in FDA's change of mind was the flood of letters from doctors which stressed their real need for the drug. These letters suggested that Parnate®, in many instances, may save the lives of depressed suicidal patients. A significant number of such patients responded to no other therapy. When the drug was no longer available, many of the patients regressed.

These experiences, the world's medical literature, the results of controlled studies, and the views of psychiatric authorities were all reviewed by the FDA, which finally decided that (when carefully used) the benefits of Parnate® outweighed its risks. The episode emphasizes the need of close consultation by the FDA with qualified members of our profession when major administrative action is contemplated.

The story also highlights the democratic tradition which generally tempers American bureaucracy. The FDA was right in flashing a red light when serious ill effects were reported. The manufacturer was right in yielding to the FDA demand—but in filing its protest and cooperating 100 per cent in an effort to develop safe prescribing procedures for Parnate®. The FDA was right in consulting medical experts before reaching its final conclusion. Neither an unrestrained profit-conscious industry, nor a dictatorial bureaucracy should be allowed to flourish in this segment of American activity. And, in this case, both the Government and the industry worked together.

Frozen Sperm and Future Progeny

George Washington had no children. But if current technics in freezing seminal fluid had been available in the eighteenth century, the Washington sperm could have been swiftly frozen and kept in storage indefinitely. Then, willing recipients could receive the thawed-out sperm, targetted at the cervix. This would enable women in every generation to become mothers to George Washington's children. Thus, our first president could have become the father of his country.

These science-fiction musings spring out of a report made recently in Miami to the American Society for the Study of Sterility.*

Dr. William Perloff of Philadelphia's Albert Einstein Center said that thawed-out, prefrozen seminal fluid had produced term pregnancies in six of eight women volunteers whose husbands were willing but azospermic. The seminal fluid is frozen in liquid nitrogen at minus 196 Centigrade degrees. Dr. Perloff believes that such fluid can be stored in a deep freeze indefinitely. It is thawed out by simply placing the vials in tap water for 5 minutes. A syringefull is then introduced in and around the cervix, with the recipient in the supine position.

Three were followed by conception in the first month after insemination; one needed two months; the others took longer.

One interesting use of this technic is to keep the husband as the donor. This could occur in

* Factual items in this editorial are based on a story in the July 20, 1964 issue *The Medical Tribune* (New York City).

two situations: (a) oligispermia, where the scanty spermtozoon supply could be centrifuged, and the concentrate pooled day after day until a sperm-rich fluid was obtained. Chance of pregnancy would obviously be much better if this highly concentrated high-sperm fluid were used; and (b) where, during the most fertile phase of the ovarian cycle, the wife could be given seven inseminating injections a day—an activity that (by doing what comes naturally) might be beyond the powers of most husbands.

What really stirs the imagination, though, is the possibility of building sperm banks. One could visualize row after row of tankards of frozen semen. One would be labeled "blue-eyed fathers"; one would carry the genes of musical genius; one would come from tall heavy fathers; another, from mathematicians or slim men or brilliant linguists. Conversely, it might be advantageous to breed a crop of imbeciles and morons to do monotonous work requiring strong backs and weak minds; thus the sperm bank could furnish genes from low I. Q. donors. We could have another section in which the great men of the world would contribute their seed to be stored indefinitely. Either way, in a world of instant paternity, it would be a wise child who—you know what.

The Health of the Nonwhite Population

The passage of the Civil Rights bill has alerted us to the need for admitting all God's children into the full opportunities offered in this country. One of the sad differentials between white and non-white* is in the area of health. Life expectancy is now 71 for the white infant but only 64 for the nonwhite. Yet nonwhites now account for 12 per cent of our population. Today, white men and women 25 and over have completed an average of 10.7 and 11.3 school years, respectively; while among the nonwhites the comparable figures were 7.3 and 8.1. A similar trend prevails for income: The median for nonwhite families last year was only 55 per cent as high as that for whites.

*The U. S. Census Bureau classes as "nonwhite" Negroes, American Indians, Chinese, Japanese, Filipinos, Koreans, and Asiatic Indians. Some of the state statistical divisions classify Americans of Mexican or Puerto Rico origin as "nonwhite" which, of course, is incorrect.

Nonwhite males currently have a considerably higher mortality than females, and the differential between the sexes has widened steadily since the turn of the century. But among nonwhites, the relative size of this gap has lagged some years behind that of whites, especially because the improvement for nonwhite females has been less rapid than that for white females.

Malignant neoplasms were, until recently, one of the few major causes of death more common among whites. But by 1950 the more rapidly rising nonwhite rate began to exceed the white. This upsurge in cancer mortality among nonwhites is associated, at least in part, with the accelerated movement since 1940 of nonwhite population to urban centers, with resultant improvements in diagnosis and more complete case-finding. Suicide has been consistently *less* common among nonwhites.

Among nonwhites 13 maternal deaths occur per 10,000 live births; almost four times as many as among whites. Among whites, 97 per cent of the registered live births in this country occurred in a hospital; for nonwhites the comparable figure was 76. These proportions represent considerable improvements; as recently as 1940 they were 60 and 27, respectively.

These differential factors are all of a pattern. Lower income and poorer educational background reduce the possibility of getting into medical schools. Race prejudice is not unknown even on hospital staffs. Many training programs, particularly those involving residencies, are reluctant to admit nonwhite trainees. Marginal incomes make it harder to live in sanitary surroundings. Forcing Negroes to live in segregated ghettos leads to higher disease rates—not to mention the aggressions born of frustration.

It has been one of Medicine's boasts that it makes its special services available to all human beings regardless of race, religion, or ethnic background. We have a proud and liberal record in New Jersey, and in spite of some backsliding by the occasional individual bigot, we have the decency to be ashamed of prejudice and discrimination. The next frontier in this is the health of the nonwhite population. There is simply no more reason for morbidity and mortality rates to vary with race than for them to vary with religion.

ORIGINAL ARTICLES

A rare combination of malignant lymphoma, bone-marrow plasmacytosis, hyperglobulinemia, and peripheral neuropathy is here reported.

Malignant Lymphoma — A Case with Plasmacytosis and Hyperglobulinemia

J. Kent Young, M.D./Mount Holly

E. C. H. Schmidt, Ph.D.,M.D./Easton, Md.

A close relationship has been noted between plasmacytosis of the bone marrow and myeloma-type serum proteins in some patients with malignant lymphoma or lymphatic leukemia.[1] In the series reported by Osserman[2] and in another by Waldenstrom a 30 per cent incidence of carcinomas of diverse types was found in patients with "monoclonal gammopathy," a dyscrasia of a single clonal unit. The following case report should stimulate further thought about the interesting interplay beween lymphocytes, plasma cells, deranged serum proteins, and disease.

A 48 year old farmer and gas station attendant was at the University Hospital, Baltimore, in 1957 and 1959 for aphthous stomatitis and a vaccination reaction. Smallpox vaccine had inadvertently been given subcutaneously for the recurrent stomatitis. He was later admitted to the Easton (Md.) Memorial Hospital because of numbness and pain on the radial side of both arms and hands with burning in the thumbs and index fingers. He had lost 20 pounds in the past two years. He had had viral pneumonia five years previously and four bouts of rapid breathing with weakness during the past three years. On admission to the Memorial Hospital, he looked older than his stated age. Temperature was 100.4; pulse 84 and regular; blood pressure was 116/80. His mouth was tight, the eyes sunken with injected and slightly icteric sclerae, the toes and fingernails had a bluish hue, and there was intermittent mottling of the skin of his hands. Old ulcers of the oral mucosa were healed but there was an eroded, moist area to the right of the anus. A small left supraclavicular node was palpable without generalized lymphadenopathy or palpable hepatosplenomegaly. There was slight distention of the neck veins. The chest was hyperresonant with medium rales at the right base laterally. No cardiac enlargement or murmur was evident. Some tremor of the hands and tongue was noted with moderate loss of sensation of light touch, pain, and vibration over both thumbs and forefingers as well as the left middle finger. Position sense was intact, but there was weakness of the fingers and wasting of the intrinsic hand muscles. He could differentiate hot and cold. He was very sensitive to cold on immersing his hands in ice water without any reflex vasodilatation or excess mottling thereafter. Deep tendon reflexes were active throughout; the plantar reflexes were normal. The right testicle was larger than the left.

Hemoglobin was 15 grams; sedimentation rate was 38. The white cell count was 6250 with 54 per cent lymphocytes (many atypical); a trace of albumen in the urine; alkaline phosphotase, 5.3 units (normal 1.5 to 4); BSP, 14 per cent retention of dye; total protein, 7.8 grams with albumen 3.6, globulin 4.2, A/G ratio, .85/1 and serum protein electrophoresis (paper) with a very dense, discrete band near the normal gammaglobulin. Aerobacter aerogenes sensitive to furadantin was isolated from the urine. Chest x-ray was unremarkable and an L. E. preparation was negative. Lumbar puncture produced an opening pressure of 75 millimeters of fluid which rose to 140 with abdominal straining and fell to 75 with relaxation. The fluid contained 162 red cells, 11 mononuclears, 60 mgm. per cent of protein, 71 of sugar, and 122.12 milli-equivalents of chloride. Intermediate strength P.P.D. was positive. Sternal bone marrow aspiration revealed a cellular specimen with 12 per cent plasma cells in various stages of development. Myeloid, erythroid, and megakaryocytic cells were normal. No Bence-Jones proteinuria was found.

The patient was reluctant to submit to diagnostic biopsy and was started on urethan 1.5 grams three times a day plus nitrofurantoin. There was subjective improvement with less pain and better co-ordination of his fingers though intermittent fever persisted with a transient "fever blister" of the upper lip. He was discharged on these two drugs and took nitrofurantoin for ten days thereafter, the urethan being tapered and stopped because of nausea and vomiting after one month. Bouts of dyspnea began at this time with some coughing up of thick, scab-like plugs of phlegm.

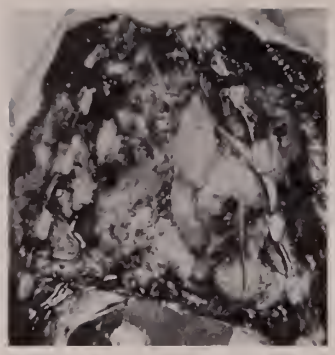


Figure 1. The open chest at autopsy showing widespread infiltration by the tumor with an incision through tumor and myocardium.



Figure 2. The gross appearance of the right and left testicles, the right being largely replaced by tumor.

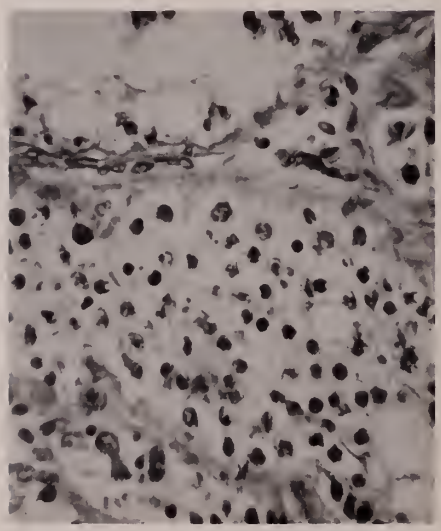


Figure 3. Microscopic section of the right testicle showing undifferential cells with irregular nuclei in various stages of mitosis.

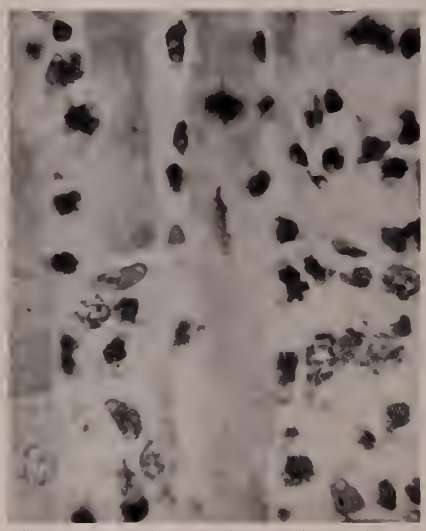


Figure 4. Microscopic section of the myocardium showing separation of the muscle fibers by tumor cells.

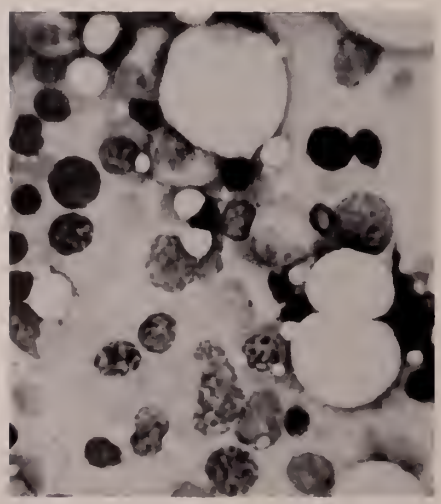


Figure 5. Microscopic section of the bone marrow with a predominance of undifferentiated cells, plasma cells, and erythroid elements.

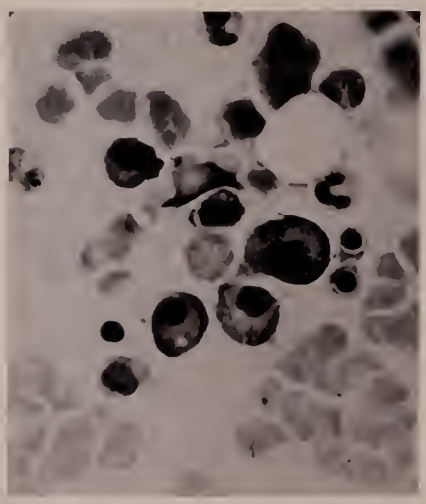


Figure 6. Bone marrow using pyronin stain and showing frequent plasma cells.

A month later, he was re-admitted. Now the pulse was 112; respirations 36; blood pressure 96/60; and temperature 99.2. The neck veins were distended 6 centimeters above the clavicles with accentuation when coughing. There was moderate pallor, mild cyanosis of the nail beds, and some left supraclavicular nodularity with bilaterally enlarged inguinal nodes. The left border of cardiac dullness was at the anterior axillary line. He showed a gallop rhythm with a mushy first sound at the apex, distant sounds at the base, and no audible pericardial friction rub. There was a wider area of upper mediastinal dullness in the supine than in the sitting position. The lungs were clear, the left tonsil was brownish-gray with ulcers, he spoke in a harsh whisper, and the vocal cords moved little towards the mid-line. Sensory and motor changes in the hands persisted, and the radial pulse was weak though no paradoxical pulse could be demonstrated.

Direct laryngoscopy did not show evidence of tuberculosis or neoplasm. Throat and sputum smears and cultures were negative for acid fast bacilli. Escheridia coli and staphylococcus epidermitis were present in the pharynx, coagulase positive staphylococcus aureus in the urine. The hemoglobin was 15, the white count was 6250 with 66 per cent segmented neutrophils, 16 per cent stabs, 16 per cent lymphocytes, 1 per cent juveniles, and 1 per cent eosinophiles. X-ray revealed marked enlargement of the cardiac contour when compared with the film of a month earlier. Fluoroscopy showed diminished cardiac pulsations with maximum dampening at the left lateral apical border. On electrocardiogram there was decreased voltage with T wave inversion in leads 1, 2, AVL, AVF, and V4-V6. The decholin circulation time was 17 seconds from arm to tongue and the venous pressure 170 millimeters saline.

A liter of sterile, turbid, amber fluid was aspirated from the pericardial sac with marked decrease in the area of cardiac dullness but little subjective improvement. Then the blood pressure rose to 110/70. Four days later, the procedure was repeated because of dyspnea and increasing cardiac dullness. Now only 100 cubic centimeters of serosanguinous fluid was obtained. His condition became progressively worse. He died five days later. A finding reported after the patient's death was neoplastic cells in a millipore filtrate of the pericardial aspirate.

AUTOPSY: The chief post-mortem finding was a tumor mass in the superior mediastinum encasing the pulmonary artery, superior portions of the pulmonary vein, the aorta, and the branches from its arch as well as invading the pericardium and myocardium (Fig. 1). The heart weighed 1500 grams with marked pericardial (15 millimeters) and myocardial (30 millimeters) thickening due to tumor which so infiltrated the left ventricular wall that it could be readily flecked with the thumb nail. On rupturing the capsule of the mass a thick, creamy material poured forth. There were large superior mediastinal lymph nodes. Several poorly defined pale foci were noted on section of the right kidney. The right testicle, largely replaced by tumor, weighed 80 grams, the left, 20 grams (Fig. 2). One half of this tumor appeared deep red, the other more pale with yellow flecks in it.

The tumor was composed of undifferentiated cells in which many nuclei were markedly irregular with many in various stages of mitosis. The rare mature cells resembled lymphocytes, as pictured in the right testicle (Fig. 3). The stromal elements were few and delicate. Some of the lymph nodes were wholly or partly replaced by the undifferentiated tumor while others showed marked endothelial proliferation. The myocardial fibers were widely separated by highly undifferentiated lymphocytic cells and in areas the myocardium was completely replaced by the tumor (Fig 4). Section of both the spleen and bone marrow showed a prominent plasmacytosis (Fig. 5), the plasma cells being accentuated by pyronin stain, even as seen in a black and white photograph (Fig. 6). In the spleen there was broadening of the cords of Billroth. The liver showed the changes of chronic congestion. The final diagnosis was malignant lymphoma, unclassified, involving the testes and abdominal and thoracic viscera.

This patient is presented to stimulate speculation about the differentiation of some lymphomas and multiple myeloma, about the effect of lymphocytes and plasma cells on serum proteins, about the incidence of plasmacytosis in cancer per se, and about the very nature of lymphocytes and plasma cells.

Azar, *et al.*[1] reported that 10 of 13 cases of malignant lymphoma or lymphatic leukemia associated with abnormal serum proteins characteristic of multiple myeloma showed a marked plasmacytosis or the presence of large numbers of pyroninophilic reticulum and lymphoid cells. Pyronin, having an affinity for ribonucleoprotein, stains deep red the cytoplasm of plasma cells, mast cells, some undifferentiated reticulum and lymphoid cells but does not stain histiocytes, most reticulum cells, lymphocytes, or normoblasts. Six of these 13 patients had over 10 per cent plasmacytosis; one had strongly pyroninophilic reticulum cells resembling immature myeloma cells, and three showed a majority of the lymphoid cells to contain abundant cytoplasm with a strong affinity for pyronin. Transitional forms (pyroninophilic mesenchymal cells) between reticulum cells and lymphocytes on one hand and plasma cells on the other hand were frequently encountered. In 25 control patients with lymphoma or leukemia without myeloma-type serum proteins only one showed plasmacytosis. This was a patient with reticulum cell sarcoma, 25 to 50 per cent plasmacytosis, and marked increase in gamma globulin. The authors interpreted these findings as indicating "a cellular derivation and a potential metabolic disturbance common to some lymphatic neoplasms and the plasmacytomas." Two cases were cited with clinical multiple myeloma but 85 per cent lymphoid cells in the bone marrow as well as one with Hodgkin's granuloma and an increased fast gamma globulin component with many plasma cells in tumor areas. Recent methyl-green pyronin Y stains of the original bone marrow

smears from our patient show many pyroninophilic plasma and lymphoid cells (Fig.6).

Paris and Bakke[4] reported a case of agranulocytosis with 61 per cent plasma cells in the bone marrow. A number of conditions including carcinomatosis, tuberculosis, syphilis, rheumatic arthritis, anarthritic rheumatism, and hypersensitivity states have been associated with plasmacytosis of the bone marrow. The ratio of size of nucleolus and nucleus (n/N ratio) was found by Aherne[4] to distinguish reliably between myelomatosis and a plasmacytic response. The mean n/N ratio was 0.26 in 10 cases of plasmacytic response whereas a mean n/N ratio of 0.41 was found in their cases of multiple myeloma. The n/N ratio in the case herein reported is 0.20. Morphologic characteristics as a central nucleolus, thick nucleolar membrane, and prominent nucleolus-associated chromatin help to differentiate the myeloma cell.

Stickler and Pinkel[5] reported 4 per cent of nucleated cells in the bone marrow to be plasma cells in eleven of 120 patients with acute myeloblastic leukemia. The authors discuss a 12-year-old girl with acute myeloblastic leukemia, a staphylococcus aureus infection with an exanthematous rash and temperature 104 who showed a temporary rise in bone marrow plasma cells to 25 per cent with rapid increase in gamma globulin to 4.86 grams. It was speculated that this was a reaction to penicillin. Robertson[5] reported two cases possibly related to sulfadiazine therapy with a ten day lag between the maximum marrow plasmacytosis and peak in gammaglobulinemia.

Hypoalbuminemia has been found to accompany human cancer often and there is a significant correlation between its depression and the rise in plasma cells in the marrow according to Sandberg *et al.*[6] Those with more advanced cancer have more plasma cells in the marrow. Although alpha globulins and fibrinogen are often elevated in patients with cancer, the gamma globulin is sometimes low late in the disease. In 600 patients with advanced and varied cancer, 45 had more than 2.5 per cent plasma cells in the marrow. Gellhorn *et al.*[7] observed over 95 per cent of lymphomas with hypogammaglobulinemia to have chronic lymphatic leukemia or lymphocytic lymphosarcoma. They do not mention any plasmacytosis in these patients. Lymphocytes and plasmacytes may both function primarily for synthesis and storage of nucleoproteins. Kelsall[8] states that plasmacytes probably arise from small lymphocytes. The interplay between lymphoid cells, plasma cells, serum proteins, and malignancy will, one day, be orderly fact.

Summary

A 48-year-old man with malignant lymphoma involving the testes and abdominal and thoracic viscera with increased numbers of plasma cells in the bone marrow and hyperglobulinemia is presented. The patient also is an example of peripheral neuropathy appearing as an early manifestation of malignancy. The relationship between plasmacytosis in the marrow, abnormal serum proteins, and disease is discussed with some speculation about the various combinations observed. Cells with affinity for pyronin stain were found in this man's bone marrow as in other patients with myeloma-like protein derangements and lymphoma or lymphatic leukemia. Careful study of the nucleus of the plasma cells with measurement of the nucleolar/nuclear ratio may prove helpful in distinguishing myeloma cells from plasma cells not related to multiple myeloma.

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150 Madison Avenue (Dr. Young)

Dr. Peck here gives us in a wonderfully compact package, a veritable monograph of industrial dermatology.

Occupational Dermatology*

Samuel Peck, M.D./New York, N. Y.†

Occupational Dermatology might cover dermatoses caused by internal (inhalation and absorption) as well as external industrial exposures. For all practical purposes, however, the dermatologic manifestations of occupational origin are of external origin, at least initially. Thus the subject, for the most part, covers contact dermatitis. This is definable as the inflammatory changes produced in the skin and its appendages by externally encountered irritants. Practically all contact dermatitis is due to chemical agents, and these may be either primary irritants or sensitizers. While the allergic contact dermatitis is perhaps more of a problem in industry, the majority of cases are due to primary irritants rather than to sensitizers. For the sake of brevity, I will limit my presentation to that type of contact dermatitis which is *not* due to physical agents—such as trauma, heat, cold, and radiant energy.

In the last ten years many new substances and processes have been introduced as part of the industrial environment. Many of them have caused occupational dermatitis. Although one would think that the introduction of these new chemicals and processes would produce new causes of occupational dermatitis, actually the basic mechanisms for the causes of occupational skin diseases have not changed. It is essential to think of our chemicals causing industrial skin diseases as primary irritants and sensitizers.

Primary Irritants

A primary irritant is an agent which will cause dermatitis by direct action on the normal skin at the site of contact if permitted to act in enough intensity or quantity for a sufficient length of time. I subdivide the primary irritants into three main groups.

1. *The Obvious or Severe Irritants.* In this group are found acids and alkalies, such as sulfuric acid and sodium hydroxide. They fulfill the definition, since with sufficient concentration and long enough contact they always produce irritation. They are *obvious* primary irritants because they are always labled with a warning or a poison label. Most of the skin injuries from contact with this group (especially in a concentrated form) are due to accidental exposures.

Burns and dermatitis due to the inorganic acids make up about 3 per cent of the total number of occupational dermatoses reported in the United States. Concentrated acids will combine avidly with the water in the skin and thus cause a burn. The most extensive lesions are those produced by the concentrated alkalies.

The principle alkalies which account for industrial skin diseases are the compounds of potassium, sodium, ammonium, and calcium. The severe burns caused by sodium hydroxide are due to its powerful keratolytic action. A high concentration of a compound like sodium hydroxide is a powerful keratin solvent and can cause severe burns and even ulcerations. In lower concentrations, this chemical as well as other alkalies will produce various degrees of dermatitis. For instance, trisodium phosphate in the form of its dust is a frequent cause of dermatitis. It is found among those workers who use it as a cleaning material.

Quick-lime or unslaked lime may cause dermatitis and ulcers. Calcium oxides absorb water to form slaked lime and in the process generate

*Read May 19, 1964 at the 198th Annual Meeting of The Medical Society of New Jersey in Atlantic City.

†From the Department of Dermatology at the Mount Sinai Hospital, of which Dr. Peck is director.

much heat. The heat of solution of even a single gram of calcium oxide is over 18,000 calories. If there is a little moisture on the skin and a particle of calcium oxide is deposited on it, it must be removed swiftly before the lime is wetted. After exposure to lime dust, the worker should not take a shower or wash his hands to remove the irritants.[1] If water is used at all, it must be used under pressure which will mechanically and immediately remove the particles before they become wet. An understanding of the manner in which a primary irritant produces its injury or dermatitis is important for both prevention and treatment.

Other obvious irritants are metallic mercury and chrome, which cause lesions of the skin and mucous membranes. Chrome ulcers resulting from fumes are often found on the mucosa and nostrils of workers exposed to steam from boiling bichromate solutions. Workers exposed to such vapors should not have broken skin. Even insect bites may predispose them to ulceration.

Most of the cases of dermatitis we now see from chromates are due to the salts and *not* to the acids. They are usually in the form of allergic contact dermatitis. These have been seen in railroad workers ever since the introduction of the diesel locomotives and the use of bichromate solution as coolants. Chromate dermatitis is also seen among the general population because of their use as tanning agents in leather. They are often responsible for "shoe leather dermatitis."

Mild Primary Irritants

In this group are included chemicals which usually produce their dermatitis after a more prolonged contact or over-exposure. An anatomic or physiological predisposition also plays a role.

Many of these primary irritants are used because they are obligatory primary irritants. In normal usage, exposure is of short intermittent duration. One may not be even aware that there is an exposure to irritants in the usual sense of the term. An example of this type of irritant is soap—and cleansing materials in general. Some synthetic detergents, of course, are also included.

Soaps—For their cleansing action, soaps depend upon the emulsification of the superficial dead cells of the keratin layer as well as the dirt on the skin surface embedded among them. To accomplish this, there must be some chemical action on the upper layers of the epidermis. Even the mildest soap produces some degree of inflammatory reaction even though it may be below clinical level if the contact is not too long. In ordinary usage on the normal skin, this irritating action is not obvious.

A cake of ordinary toilet soap is a suspension of anhydrous soap crystals. *Kraft's point* is the temperature at which a soap is soluble in water, forming a clear solution. Above Kraft's point a "sol" is obtained; a *kurd* or *gel* is formed below this point. In very dilute solution (0.01M), soaps have a conductivity comparable to that of strong electrolytes and are completely dissociated into ions.

Mixtures of properly chosen fatty materials saponified with sodium hydroxide solution of adequate concentration under constant heating yield, after separating and washing, a solution of soap with 60 to 63 per cent fatty acid content which is called "neat soap." After cooling, this solution gives ordinary household soap; and after concentration (if the quality of the fatty materials is suitable), toilet soap which contains 78 to 80 per cent fatty acids. To these are added: the perfume, the coloring material, a stabilizer to guard against auto-oxidation, and, sometimes, superfatting agents such as lanolin.

The reactivity of soap in solution depends on its water-sodium hydroxide equilibrium. There is usually a small amount of free alkali. This reaction determines the pH of the soap, since the pH value depends not only on the amount of water present but also on the nature of the radical R. A properly manufactured good quality soap does not contain more than 0.03 per cent free alkali calculated as sodium hydroxide. A soap thus can be defined as the salt of an alkali and a fatty acid. The salt is usually sod-

ium or potassium hydroxide, both of which are strong alkalies. The fatty acids most usually found are the saturated fatty acids, such as (1) caproic, caprylic, capric, lauric, myristic, palmitic, and stearic acids; (2) the unsaturated fatty acids, particularly oleic and linoleic; and finally (3), the hydroxy fatty acids, such as ricinoleic.

Blank[3] carried out patch tests with various pure fatty acids and mixtures of fatty acids. He found that saturated fatty acids of low molecular weight yield a much higher proportion of positive (primary irritant) reactions to patch tests than do acids of higher molecular weight. Strangely enough, he found that persons with normal skin give positive reactions to the fatty acids of low molecular weight as frequently as do persons with pathologic skin. Positive reactions to the unsaturated fatty acid and oleic acid occur about as frequently as do positive reactions to the saturated acids of high molecular weight. A positive reaction to the mixed fatty acids from castor oil is seldom seen. He suggests that neither the alkali nor the fatty acid alone is responsible for the irritation produced by soap, but that each is a contributing factor; and that the higher the molecular weight of the fatty acid, the more alkali will be required before irritation results.[3]

Guilane and Blank[4] have pointed out that sodium stearate and sodium palmitate elicit a relatively low incidence of significant positive reactions to patch tests.

My own experience is that several thousand prophetic patch tests with leading toilet soaps failed to elicit any reactions of sensitivity. A mild reaction of primary irritation was often elicited after 24 hour contact with a 4 per cent or a 3 per cent soap solution.

Since soaps are salts of weakly ionized fatty acids and strongly ionized alkalies, an alkaline solution always results on hydrolysis. In the nine most popular toilet soaps that I tested (starting with a tap water control of about 7.1), their pH varied from 9.45 to 10.1.

This alkaline solution is generally well tolerated by the normal skin when soaps are used within normal range of exposures. The surface of a healthy skin (by means of the buffering action of the surface acids and especially the keratin) is able to recover its normal pH (between 3.5 and 4.6) after exposures to even a fairly alkaline toilet soap. Exposure to a good toilet soap causes a transitory shift of the pH of the skin from the acid to the alkaline side for about one hour in the typical case before the acid pH is restored. In subjects with particularly poor buffering capacity of the keratin, it may take as long as 2 to 3 hours.

The pH on the skin on the arms of infants (two weeks to twenty-four months of age) is approximately the same. Most showed a pH under 5. The range was from a pH of 4.1 to 5.9. The buffering capacity of the infants and young children is about the same as that of adults.

Immediately after washing with a soap solution of about pH 10, the pH of the dried skin rose an average of 2.55 units in contrast to a pH rise of only 0.97 units right after the use of a neutral detergent. In 75 per cent of all trials, the skin sites to which the soap solution was applied required more than 60 minutes to return to their base levels. When the neutral detergent solution was applied[5], only 6 of the skin sites failed to return to their base levels within 60 minutes.

Kantor[6], in a double-blind cross-over study on the effects of toilet soap on the senescent skin, could conclude that dryness and scalings of the senile skin is the result of desiccation of the horny layer. He found that this was intensified by the use of alkaline soap and lack of lubrication. He recommended a neutral detergent bar containing a fatty acid emollient for the routine cleansing of older individuals. And Bettley[7] has found that patch tests with soap on the apparently normal skin of subjects with eczema produced irritant reactions more easily than normal subjects.

Peck[8] *et al* were able to demonstrate that alkaline soaps were not the cleansers of choice for the dermatitic skin. They also pointed out that, in well documented instances of soap intolerance, a neutral superfatted cleanser was well tolerated.

Insidious Primary Irritants

I include in this group those chemical agents which take months or years before they produce any characteristic type of dermatitis. The resulting dermatitis sometimes is so characteristic that one can make a diagnosis of the etiologic factor by the type of skin eruption produced.

Good examples are occupational acne, adhesive tape dermatitis, and leukoderma.

Adhesive Tape Dermatitis—Adhesive tape may produce an allergic contact dermatitis which is well characterized clinically and microscopically. This reaction is rare. It is practically impossible to trace the specific sensitizer in any adhesive because the chemical composition of the ingredients varies from batch to batch and is often a company secret. Adhesive tape can also produce a fleeting, unimportant "reaction of removal." This is due to mechanical removal of the tape, especially when a tacky adhesive has been used. Peck *et al*[9] find that most cases of adhesive tape dermatitis are due to a specific mechanism which can be summarized as follows:

The initiating factor in most instances (if not all) is a plugging of the ostia of the sweat ducts by keratin. The development of the "sweat retention syndrome" (Sulzberger, Hermann and co-workers) and the production of what may be referred to as a miliaria rubra follow.

Differences in the formulation of the adhesive tape may account for more irritation from some tapes than from others. Once plugging of the sweat ducts takes place, the bacteria may multiply under the tape and add to the maceration and irritation.

Attempts have been made to formulate adhesives which would give a minimum amount of this type of what might be called primary irritation due to a specific mechanism. Unfortunately, the tackiness of the adhesive and the materials necessary to make it adhere tend, on the one hand, to plug the sweat ducts and, on the other, to stimulate keratinization of the sweat ducts as above described. Ingredients have been introduced which are calculated to minimize the growth of bacteria under the adhesive. Such bacteria seem to play a role in many instances in the production of dermatitis.

Chloracne is a type of eruption seen after exposure to insoluable cutting oils, crude petroleum, coal tar, coal tar pitch, and especially the chlornaphthalenes, chlordiphenyls, chlordiphenyloxide, the solid chlorbenzols, and the chlorphenols.[10] The acneiform lesions caused by the chlor compounds are more striking than those produced by other acne-forming substances. Although the acnes caused by these compounds have been called "chloracnes," chlorine gas itself causes no acne-like lesions. Nor do the inorganic compounds of chlorine cause them, either by external contact or by internal administration. Acneiform lesions have not been seen among workers exposed to the solvent chlorinated hydrocarbons, although all of the solvents can injure the skin by direct contact and can cause systemic poisoning when absorbed. Naphthalene, diphenyl, benzol, and phenol without chlorination do not cause acneiform lesions. Only when they are combined with chlorine do they have this effect upon the skin.

To those familiar with the action of these chemicals, simple inspection of a patient with chloracne will point to the type of exposure. For instance, exposure to cutting oils and insoluble crude petroleum will cause folliculitis, pustules and furuncles, and even comedones, with the site of predilection on the hairy regions, including even the backs of the hands and fingers. This is different from the ordinary sites of acne vulgaris. In acneiform lesions, after exposure to coal tar or coal tar pitch (or even heavy coal tar distillates) in addition to the comedones and many small cysts, there may be melanosis. Usually, no inflammatory reaction is present.

The so-called chlornaphthalenes and the solid chlorphenols produce the most characteristic forms of occupational acne. Here the comedones are not so prominent, but many straw-colored non-inflammatory cysts are seen.

Cocci (commonly found in the lesion of acne vulgaris) are not seen in the contact-irritant acneiform lesion.

Sensitizers

A cutaneous sensitizer is an agent which (while it may not cause demonstrable cutaneous

changes on first contact) may affect such specific changes and so sensitize the skin that after five to seven days (or more) further contact on the same or other parts of the body will cause dermatitis. The sensitizers cause the true allergic contact dermatitis which is often used synonymously with allergic contact eczema or just contact eczema.

Both the definition of a primary irritant and a sensitizer are important because, from the history of the development of a dermatitis, the primary irritant will manifest its action without an incubation period; sensitizers, by contrast, take a minimum of five to seven days before dermatitis can develop unless there has been a previous sensitization.

It is the action of the weak primary irritants such as toilet soaps which cause confusion in diagnosis and treatment because they very often enhance an allergic contact dermatitis or even that due to primary irritation.

Sensitization to Facial Tissues—Facial tissues with "added wet strength" have recently been introduced for public use. A resulting dermatitis has been noted around the mouth and nose, sometimes on the eyelids and, on rare occasions, around the rectum and genitalia.[11]

The frequency of the localization to the eyelids and side of the nose and chin would lead us to suspect a possible nail polish dermatitis. The author with Palitz[11] was able to show that "wet strength tissues" were capable of producing a sensitization dermatitis. The reason is that "wet strength" was due to impregnation with urea formaldehyde or melamine formaldehyde resins. Once the dermatitis was established, it was shown that the actual sensitizer was the formaldehyde component. In some instances, patch tests with the tissue gave either a negative or a weakly positive reaction while the formaldehyde in proper concentration gave a strongly positive patch test.

Carrot Dermatitis—In 1944, Peck *et al*[12] reported a sensitization dermatitis due to contact with carrots and carrot juice. This was the first report in the United States, though in 1941 Vickers[13] of England had published reports of carrot dermatitis. Klauder and Kimmich[44] have recently reported their findings. All agree that sensitization dermatitis due to carrots was infrequent. However, once it occurred, a sensitization to the vegetable in the umbelliferae family could also occur. Members of this family include anise, fennel, caraway, dill coriander, parsnip, turnip, rooted celery, pascal celery, and parsley.

Newly Introduced Chemicals

Many new chemicals act as both primary irritants and (in higher dilutions) as sensitizers. Samitz[14] has presented a fine summary of most of these newer compounds through 1953. Birmingham[15] has reviewed the industrial irritants introduced since then.

Insecticides—Among these must be included D. D. T. (dichloro-diphenyl-trichloro-ethane), chlordane (octhachloro-methano-tetra-hydrondane, chlor-kil, orthoklor, chlorotox), benzine hexachloride (BHG, 666 gammaxzne, Lindane®), Toxaphene® (chlorinated camphene), Aldrin® (octalene compound 118), dieldrin (octalox, compound 497), and others.

Not only may these compounds prove irritating *per se*, but their solvents are also irritants. With some inhalation and skin absorption may lead to systemic poisoning.

The *thiocyanates*: a group of insecticides including the lethanes are also capable of skin irritation. They are, in addition, toxic through skin absorption.

The organic phosphates—such as hexaethyl tetraphosphate (HETP), tetraethyl pyrophosphate (TEPP), and others—can even cause death by absorption through the skin.

Beryllium can cause granulomatous lesions in the skin. Van Ordstrand *et al*[16] pointed out, as have others[17], that contact with beryllium sulfate, fluoride, and the oxyfluoride may produce dermatitis and ulceration.

Pyre and Oatway[18] and Grier, Nash and Frieman[19] have described contact dermatitis from beryllium sulfate or fluoride, ulcers due to the deposition of soluble beryllium salts in the tissues, subcutaneous granulomas occurring in

persons who cut themselves on fluorescent lamps, as well as granulomas in the lungs. Stoner and Eisenbud[20] state that beryllium is both a primary irritant and a sensitizer. They even explain the formation of the skin granulomas on the basis of an antigen-antibody reaction. Cobalt can also cause an allergic contact dermatitis.[21]

Selenium—Vesce[22] reported on the dangers associated with exposure to selenium. Particularly dangerous are the oxides and acids of selenium. While in industrial exposures most of the cases of poisoning are acute, there are manifestations which are seen as irritation of the skin and the mucosae. The latter may be associated with the loss of the sense of smell and irritation of the respiratory and the gastrointestinal tract. Systemic degenerative changes are not infrequent.

Nickel—Sensitization to nickel is common. Its clinical pattern is distinctive.[23] There is a primary lesion at the site of directed contact and a secondary symetrical eruption almost like the "ids." A fifth of Calnon's cases had dermatitis on the hands.[23]

Synthetic Rubber—In addition to the basic copolymers, other chemicals are used in the manufacture of synthetic rubber. Some manufacturers use antioxidants plasticizers and accelerators, as well as solvents. The type of chemicals is constantly changing, and as each one is introduced their potential hazards must be studied. The five basic types of synthetic rubber being produced in the U. S. are: (a) butyl rubber, a copolymer of butadiene and isobutelene; (b) neoprene, a polymerized chloroprene; (c) Buna S., which is a copolymer of butadiene and styrene; (d) Buna N, which is a copolymer of butadiene and acrylonitrile or vinylcyanide; and (e) thiocol, which is a polymerized condensation product of sodium tetrasulfide and various chlorinated compounds, such as propylene dichloride and ethylene dichloride.[15] Wilson *et al*[24] reported on acrylonitrile. Some of the workers in contact with this reported marked itching but no evidence of dermatitis. However, they have been proved to be primary irritants on contact producing a vesicant action on the skin. While styrene does produce direct irritation on the skin (which is comparable to other hydrocarbons such as benzene and toluene), butadiene is non-irritating except perhaps in very high concentration. Schwartz[25] has pointed out that most of the dermatitis seen in industry from the manufacture of Buna S. is caused by the chemicals added to the butadiene and the styrene. These chemicals could act either as primary irritants or sensitizers, and they include, of course, the antioxidants and the chain modifiers. Schwartz, Tulipan, and Peck[26] have described a dermatitis resulting from exposure to the various chemicals formed and used in the process of the manufacture of synthetic rubbers.

Leukoderma Due to an Antioxidant—Schwartz *et al*[27] were the first to point out that leukoderma developed in workers due to contact with the monobenzyl ether of hydroquinone secondary to the wearing of rubber gloves containing this antioxidant. Peck and Sobotka[28] were able to point out that monobenzyl ether of hydroquinone was a specific oxidase poison for the enzyme associated with normal pigmentation.

Dermatitis Among The Public Following Exposure to Textiles and Wearing Apparel—Schwartz and Peck[29] found dermatitis from new fabrics and dyes as well as various finishes used to render the fabrics flameproof, mildewproof, and through attempts at rendering the natural or synthetic fabrics wrinkle-proof, as well as the dyes, mordants, and other chemicals used in fabric finishing. The dyes are more often incriminated than almost any other chemical used in textiles and wearing apparel. Various authors have reported dyes as causes of sensitization dermatitis.

(A) Schwartz[29] lists the following:

Amino-azo-benzine
Amino-azo-toluene-hydrochloride
Aniline black
Auramine
Brilliant indiago G
Chrysoidine
Crystal violet
Hydron blue
Indanthrene violet R.R.
Victoria blue
Ionamine A
Iso-rosinduline
Malachite green
Metanil yellow
Methy violet
Orange R.
Orange Y.
Paraphenylenediamine
Ponsol dark blue BR
Safranine
Sulphanthrene pink F F
Victoria green

(B) Dobkevitch and Baer[30] reported the following dyes as having caused dermatitis:

Yellow—p-amino acetanilide—p-creasol
Orange—p-nitro aniline—p-sylidine
p-nitro aniline—aniline
Red—Mixture of: p-nitro aniline-ethyl hydroxy, ethyl aniline, and o-chlor-p-nitro, aniline-ethyl hydroxy, ethyl aniline
Blue—Mixture of: l-methyl maino 4 (hydroxy-ethyl-amino) anthraquinone and 1, 4-di (hydroxy-ethylamino) anthraquinone.

Schwartz and Peck[29] have shown that lousicides, moth-proofing, and anti-mildews are more frequent causes of dermatitis than dyes. Shoe leather dermatitis is due to the chromates used in leather tanning, rather than to the other materials which go into the manufacture of shoe leather or in the finished shoe. However, here, too, the anti-mildews as well as the adhesive materials used with the backing have been found to be factors in shoe dermatitis. Samitz[14] has reminded us of dermatitis caused by fabrics following washing or dry cleaning. He states that underclothing and shirts washed with some of the new washing powders may contain synthetic detergents, strong alkalies, and bleaches which may cause dermatitis. In some instances, clothing which has arrived from the dry cleaners contains some of the high boiling solvents used in dry cleaning solutions which have not completely evaporated from clothing. These have been shown[27] to be actual causes of dermatitis.

The after-rinses used in laundering, such as the mercuric compounds, are causes of dermatitis from diapers which have been processed by the diaper services. Hundreds of cases of dermatitis have been ascribed to such articles of wearing apparel as leather accessories, furs, girdles, finishes on socks and underclothing, dress shields, wrist watch straps, and eye glasses. Nearly all are cases of allergic contact dermatitis. To determine which of the chemicals in the wearing apparel is responsible, the dermatologist needs a vast store of knowledge about the chemicals used. Many of the dyes (as has been pointed out by Baer *et al*[43]) may give rise to cross-sensitivity reactions unless the dye material is recognized. To prevent recurrences, this must be brought to the attention of the patient so that contact with the specific or allied chemicals can be avoided in the future.

Plastics—The synthetic resins or plastics are being increasingly used, and dermatitis is becoming more and more frequent among the users of the finished goods. When the plastics are completely polymerized, they seldom give rise to dermatitis. It is the monomers and the low polymers (as well as the incompletely condensed or cured resins or their uncombined components) which bloom out on the finished material and which are the causes of dermatitis. The monomers are primary irritants as well as sensitizers. This is not astonishing, since some of the primary chemical components of resins are chemicals such as phenols and formaldehyde, among others. They are well known primary irritants and sensitizers.

In the manufacture of one of the oldest types of resin (the phenol-formaldehyde, thermosetting resins), it is the formaldehyde rather than the phenol which is mainly responsible for the sensitization which may occur. Formaldehyde is one of the most frequent causes of dermatitis in sensitization phenomena seen from the finished plastics. Here, too, it is the incompletely cured resin or the formaldehyde which has not been completely set which is responsible.

According to Nelson and McCormick,[45] 34 chemical companies employing over 20,000 workers manufacture plastic materials. More than 4,000 industrial plants with over 60,000 employees use these plastics for molded or extruded products, fabricated articles, laminated or reinforced end products, and plastic film and sheeting. Because the industry is new and because of the ingenuity of modern research, the compounds making up the plastics are ever changing.

Acrylic Resins are used in the manufacture of auto tail lights, brush backs, signs, and various types of textiles; they are also used in maxillofacial surgery and in the manufacture of prosthetic appliances for various parts of the human body. An acrylic plastic material is the replacement for blood vessels and heart valves, because it does not promote clotting. As Patty[46] points out, methyl methacrylate is inert. Its stabilizers and antioxidants have adverse effects, particularly dermatitis. Blunt (quoted by Nel-

son[47]) feels that the acrylics are better than any other previous material for tissue compatibility and that they may be used in cosmetic surgery without causing skin irritation.

Alkyd Resins are used for linoleum surfacings, paints for refrigerators and autos ignition parts, and food wrappings. These products are dermatologically inert when properly finished. However, Schwartz[48] and Tulipan[49] have reported cases of dermatitis from the alkyd resins used as finishes for textiles.

Amino (urea and melamine) Resins are used in making buttons, dishes, laminated table tops, and housings for kitchen appliances. While most observers say that these finished compounds are inert, Schwartz[48] has reported that urea-formaldehyde resins have caused dermatitis when used as finishes for textiles. While Lehman[31] states that polymers of urea formaldehyde are acceptable as a treatment for paper for food wrapping purposes only, he adds that melamine formaldehyde polymer is satisfactory for the same purpose. It is noteworthy that, when used in "wet strength tissues," these may cause dermatitis.[11]

Alkyl Resins have caused a considerable amount of dermatitis among the workers in contact with them. Not only have they produced direct irritation, but melanosis and photosensitivity has been produced.

Silicones and Silanes have recently been introduced. They represent a new class of high polymeric substances. These materials give rise to rubber-like products, among others. Rowe, *et al*,[50] have reported that the chlorosilanes may produce severe burns of the skin. Others, such as the ethoxysilanes, cause no direct dermatitis but have a drying effect like the organic solvents.

Perfume Dermatitis—It has been pointed out by Klarmann,[32] among others, that skin reactions to perfume materials are more often allergic contact dermatitis than primary irritation. Klarmann[32] has indicated that, while sometimes we find singular specificity in sensitatization to perfumes, there are cases where chemically related substances are capable of giving rise to cross-sensitivity reactions.

Examples of specific sensitivity to perfume materials have been reported by Landsteiner and Jacobs[33] with methyl hepitine carbonate. Similar findings were made by others.

Keil[34] found a patient who was sensitive to citronella oil and also showed positive patch tests of oil of lemon. Another of his patients was sensitive to oil of lemon and gave a positive reaction to oil of turpentine. Here, Keil[34] was able to show that positive patch tests could be obtained with beta-pinene. The latter is a close relative chemically of limonene and furnishes the explanation for the sensitivity to both lemon oil and turpentine.

Another problem deals with berlocque dermatitis, which has been attributed to bergamot oil. Here we do not have a true simple sensitization. Apparently a number of factors, including photosensitization, play a role. The recent experiments of Lerner, Denton, and Fitzpatrick[35] seem to indicate that it is the Psoralens present in a variety of natural, essential oils—including bergamot oil and other citrus oils—which are responsible for the hyperpigmentation of Berlocque dermatitis.

Photodermatitis—Wilkinson[36] described an outbreak of photodermatitis due to tetrachlorsalicylanilide, a germicide incorporated in an industrial soap. Exposure to ultraviolet aggravated the eruption. All of the affected workmen, however, remained hypersensitive to light.

Birmingham[15] in a recent paper called attention to the problem of the phototoxic reactions caused by diseased celery. The vesicular and bullous lesions among the white harvesters were followed by hyperpigmentation and depigmentation. Field and laboratory studies proved conclusively that the reactions were phototoxic. The action spectrum ranged from 3200 to 3700 Angstroms, with a specific peak at 3650 Angstroms. The photoreactive materials have been identified recently as 8-methoxpsoralen and 4, 5, 8-trimethylpsoralen. The latter is 15 times

more potent than 8-methoxypsoralen. The disease among celery harvesters was generally considered as another example of allergic hypersensitivity to celery oil.

There are other examples of photodermatitis produced by essential oils. Sams[31] showed that the oil of lime causes pigmentation after exposure to sunlight. Goodman[37] seems to incriminate traces of copper in the oil originating from the shipping containers, which is a necessary part of the production of sensitization and the photosensitivity. Oil of neroli and oil of petitgrain are also photosensitizers.

The work of Patterson and Hall[38] as well as that of Katz[39] seems to indicate that most of the essential oils in aromatic chemicals which go into perfumes are not primary irritants except in isolated instances.

Buckley,[40] Canizares,[47] and De Graciansky[42] have reported dermatitis from photodevelopers. These investigators found that a chemical used in color photographic development produced eruptions which were clinically and histologically indistinguishable from lichen planus. The cases began as acute eczematous contact dermatitis; they evolved into a lichen planus-like pattern. A substituted derivative of paraphenylenediamine was found to be the provoking agent.

Are the patterns of sensitivity to common contact allergens changing?—Baer and his coworkers[43] compare in a selected patient population the incidence of allergic contact sensitivity (index of sensitivity) to nickle sulfate, potassium dichromate, mercury bichloride, paraphenylenediamine and formaldehyde in 1936 and 1962. They show changes in the incidence of patch tests reactions index of sensitivity in the highly selected population group.

In their discussion, the authors considered the possibility that there has been a general lowering of the threshold to primary irritations so that previously non-irritant concentrations of test substances produce a reaction in many or all of whom they tested. I agree that this is unlikely. Probably for some of these substances there has been a relative increase or decrease in the probabilities of exposure. When I first published my paper on dermatitis due to "wet strength" resin in facial tissues, it produced a comment that very few cases have been noted in the United States; but now some have been reported from Great Britain. Baer and his coworkers[43] do report such type of allergic sensitization.

An extensive list of bibliographic citations will be found in Dr. Peck's reprints.

33 East 70th Street

Mortality Following Operation for Massive Gastrointestinal Hemorrhage

In a series of 178 operations for massive upper gastrointestinal hemorrhage, 130 were performed as emergency procedures, with a mortality rate of 28.5%. There were no deaths when elective operation was possible. Presence of a serious systemic disease was a major factor; the mortality rate for patients beginning to bleed during hospitalization for another condition was more than three times as high as for those bleeding before admission. An inverse relation of postoperative mortality to the level of hemoglobin and a positive relation to the amount of blood received were observed. Only three of the 37 deaths in this series occurred in patients receiving less than 10 units of whole blood. The most striking difference as to the type of operation was observed between gastric resection and vagotomy and pyloroplasty. Gastric resection was highly lethal, whereas in elective gastrectomy there was no death. The combination of resection and hemorrhage, rather than resection itself, is considered the lethal factor.

J. H. Foster, D. F. Hickok, and J. E. Dunphy
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The pulsating human heart was the last cavity to be made accessible to the surgeon's knife. And it is now possible to remove cardiac tumors.

Cardiac Tumors*

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Tumors of the heart involving its muscular structure (whether intracavitary or purely intramural) have become of increasing concern to the clinician. Up to just a few years ago, these tumors were of interest primarily to the pathologist and the clinician's concern was one of curiosity. He did not have available to him a method of effectively treating these tumors. During the past ten years with the development of open heart surgery, it has been possible to treat these tumors. By now, over 250 such cases have been reported and most have been treated successfully. Metastatic lesions are the most common. They are 20 to 40 times as frequent as the primary tumors within the heart. The most frequent metastatic tumors are in order of frequency: carcinoma of the breast, bronchogenic carcinoma, and malignant melanoma.

Primary tumors of the heart remain relatively rare although the diagnosis is being made with increasing frequency. Strauss and Merliss[1] in 1945 reported an incidence in autopsy specimens as being 0.0017 per cent of 480,331 cases. We have classified tumors of the heart as follows:

A. Benign
   Myxoma
   Rhabdomyoma
   Angioma
   Fibroma and Hamartoma
   Lipoma
   Cysts
B. Malignant
   Sarcoma

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The most frequent primary tumor of the heart is the myxoma. Most of these occur within the atria, two-thirds in the left atrium.

Several cases of intracavitary myxomas arising in the ventricles have been reported. This tumor is usually polypoid and arises from the septum in the area of fossa ovalis. It may prolapse through the mitral valve on the left side or the tricuspid valve on the right side, thereby causing valvular obstruction. This growth is composed of cellular loose tissue with much mucinous material from which it derives its name. Myxoma has been considered by some to be really a thrombus, particularly since it is seen in the left atrium and at times associated with mitral stenosis. However, most pathologists accept it as a true neoplasm[3].

The second most common benign intracardiac tumor is the rhabdomyoma. This occurs in one-half of the patients with tuberous sclerosis and is most common in pediatric practice. These usually present themselves in the form of nodules within the ventricles. Prichard[3] considers this tumor to be either a form of glycogen storage disease or a hamartoma.

Angiomas are uncommon among cardiac tumors. These may be sessile or pedunculated and may invade the cardiac conduction system. In the early literature the angiomas were described as varices.

Fibromas and lipomas are rare, the latter possibly being a variant of myxoma. Cystic epithelial inclusions may be encountered, and in the septum they might invade the conduction system of the ventricles. Primary sarcoma is less frequent than myxoma and is diagnosed only rarely during life. In the x-ray, this shows a

change in the appearance of the cardiac contour and frequently invades the pericardium. Approximately 20 per cent of sarcomas have polypoid projections into the cardiac chambers. The sarcoma may be fibrosarcoma, myxosarcoma, leiomyosarcoma, rhabdomyosarcoma, or lymphosarcoma.

Clinical Picture

The intracavitary tumors of the heart may present symptoms in three categories. Either they interfere with valvular function and thus cause some degree of hemodynamic obstruction, or they interfere with the conduction system by infiltrating into it, or the tumors fragment and send off emboli.

One of the commonest clinical syndromes is that of obstruction of the mitral valve caused by myxoma of the left atrium, presenting a clinical picture of mitral stenosis. X-ray of the heart usually reveals the normal contour except in sarcoma or the angiomas of the ventricular wall. If the myxoma is calcified, the motion of this tumor may be seen on fluoroscopy. The most valuable diagnostic test is angiocardiography. By this means, the diagnosis can be verified, the exact location of the tumor becomes known, and the hemodynamic obstruction caused by the tumor can be determined.

Cardiac catheterization is of limited value in the diagnosis. Indeed, it may be hazardous because of the friability of these tumors resulting in distal tumor embolization.

Angiomas as a group do not present symptoms until they interfere with the cardiac conduction system. Then they might cause complete heart block and sudden death.

Sarcomas of the heart are rarely diagnosed during life. They can cause severe heart failure which rarely responds to therapy. By chest x-ray, one might note rapid change in the size of the heart which may be due to the tumor *per se* or to acute hemopericardium which is frequently seen with this tumor.

Treatment

These tumors should be removed as soon as diagnosis is made. Early operation is indicated since (1) these tumors might obstruct the outflow tract, (2) they may invade the conduction center at any time causing heart block, (3) embolization from the tumor may occur. These growths are removed under extra corporeal circulation and it is important that either fibrillation or cardiac arrest be induced. In our experience, hypothermia has produced these desired effects with the least complications. Arrest is desired so that in removing the tumor fragmentation may be avoided. The tumor must be handled with great care to avoid breaking off any part which might enter the circulation.

Tumors of the atria are more readily removed than those of the ventricle. However, ventricular tumors can be removed. Myxoma of the right ventricle is rare, but there are at present two reports of successful removal of such a tumor; the first by Michaud[2] in France in 1960 and the second is one of our cases[4]. Vascular tumors of the heart can be treated by resection, radiation, or both.

Clinical Experience

Our clinical experience is limited to three such cases in the last four years. This indicates the relative incidence of these tumors. In view of the large number now reported in the literature (amounting to over 250 cases), the incidence of these tumors must be greater than that reported by pathologists at autopsy.

A myxoma of the right ventricle which we encountered was in a 26 year-old male who was well until he experienced episodes of fainting. He had a cardiac murmur which had not been present previously. Angiocardiography revealed a tumor mass in the outflow tract of the right ventricle (Figure 1). He was operated on under hypothermia of 20° with extra corporeal circulation. At the time of surgery, it was believed that all of these tumors arose within the atrium and prolapsed through the tricuspid valve. However, atriotomy failed to reveal a tumor and, thus, a ventriculotomy was performed. This tumor was removed by sharp and blunt dissection, and it was felt that all of the tumor was excised. The patient required two shocks to defibrillate the heart, following which he had an uneventful recovery and is now in the practice of dentistry without complaints. Follow-up examination fails to reveal any abnormalities of the heart.



Figure 1. Angiocardiogram showing a tumor mass in the outflow tract of the right ventricle.

The second patient had a hemangioendothelioma of the left ventricle. This occurred in a 10 year-old girl who had developed ascites, hepatomegaly, and gallop rhythm. At age 4, a diagnosis of pericarditis had been made and, after treatment with streptomycin and PAS, a partial pericardiectomy was performed. At that time, the contour of the heart was described as normal. At age of 10, however, there was a gross enlargement seen on chest x-ray of the left side of the heart (Figure 2). Cardiac catheterization was essentially normal. Surgical exploration, however, revealed a diffuse mass of the entire left ventricle and the mass had a gross appearance of hemangioma. A biopsy was taken and it was obvious that surgical resection would be impossible. Pathologic examination of the specimen revealed the lesion to be a hemangioma. The patient has been treated by radiation and is now free of symptoms although the cardiac contour by chest x-ray remains unchanged.

A third patient had a myxoma of the left atrium. This 32 year-old woman presented herself with clinical signs and symptoms of mitral stenosis. At operation a closed mitral commissurotomy was planned, but upon inserting the finger into the left atrial appendage, a mass was encountered. At the time, it was believed that this represented a large thrombus and since the pump oxygenator had not been made available, it was decided to reoperate this patient within two weeks. Ten days later, a right thoracotomy was performed and with extra corporeal circulation a left atriotomy was done. The tumor mass was readily removed from the atrial septum, and the patient had an uneventful postoperative period. Histological examination of the tumor mass revealed it to be a myxoma.

Summary

Cardiac tumors, although relatively rare, are seen by the cardiac surgeon. The pathologic types, clinical picture, and therapy are described. Although at one time considered to be of academic interest only, today the majority of these tumors can be removed by open heart surgery with a low mortality. Three cases which we have encountered are briefly discussed.



Figure 2. Hemangioendothelioma of the left ventricle.

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Medical Center (Dr. Timmes)

Here is a survey of the outcome of 173 soft tissue tumors of the hand and wrist treated at the Mountainside Hospital.

Soft Tissue Tumors of the Hand and Wrist*

A 10 Year Survey

Robert George Greene, M.D./Montclair

Soft tissue tumors of the hand and wrist may arise from any of the tissues of this area. Because of their location, they are often noted early. Many are related to trauma. Certain tumors have a rather well-established pattern of location or of age occurrence. Others have characteristic configurations.

Knowledge of these factors improves the chance for a correct diagnosis preoperatively and leads to more intelligent treatment.

In general, it is important to operate in a bloodless field using a pneumatic tourniquet. Because there is a known and controlled pressure, this is safer than using an Esmarch Bandage. A dry field allows complete removal of the tumor and helps prevent injury to adjacent structures. Care to protect the small digital nerves and vessels, and the use of established safe incisions, are obvious precautions in hand surgery.

This report is a survey of the experience of soft tissue tumors of the hand and wrist excised at Mountainside Hospital in Montclair, from 1953 to 1963. Most were done under tourniquet hemostasis and under general anesthesia. Most were done by surgeons of the Orthopedic Department of Mountainside Hospital. None of the tumors in this series was previously treated by x-ray or chemotherapy.

Ganglia

The most common tumor in this area is the ganglion. It occurs most commonly in young adults; and in women more often than in men. It represents almost 50 per cent of the tumors seen. Its most common locale is the dorsum of the wrist, between the extensor digitorum tendons and the long extensors of the thumb. About half of all ganglia are at this site.

The next most common area was on the radial aspect of the wrist, where 25 per cent of all ganglia were found.

The third most common area was on the flexor surface of the hand, arising from the tendon sheath of the flexor tendon in the proximal crease of the finger; and also on the flexor surface of the base of the thumb. The tumors arise from the tendon sheaths or joint capsules, but do not communicate with the joints or the synovial linings.

The common complaint was presence of a mass which varied in size from time to time, growing larger, smaller, and then again larger. In some cases, this mass interfered with function. Discomfort and moderate pain in the area of tumor was much less common.

When the tumor was large enough, it would usually transilluminate light. It was discrete and "cystic" in feel.

Recurrence rate of this tumor after excision is high in all series. Five tumors, excised in other institutions prior to admission to Mountainside Hospital, were admitted for re-excision. Only one tumor primarily excised at Mountainside

*Read May 18, 1964 before the Orthopedic Surgical Section of The Medical Society of New Jersey.

Hospital recurred and was re-excised at Mountainside Hospital. This tumor required four attempts before there were no further recurrences. It is of interest that the original attempt was done without a tourniquet and under local anesthesia.

At least fifteen surgical procedures were done at Mountainside and other hospitals to remove the ganglia in the six patients with recurrences. The obvious conclusion is that the first operative attempt should be done with extreme care.

The age incidence of the patients who had recurrences of the tumor was thirteen years younger than the group as a whole. So far as I know, this observation has not been made before. I am not sure of its meaning.

A rather large group of patients admitted for ganglion removal had had treatment consisting of external rupture, injection with hydrocortisone or hyaluronidase prior to hospitalization. Obviously in each of these, this type of treatment had failed. I have no way of knowing in what proportion of cases such treatment is successful.

The carpal tunnel syndrome secondary to a ganglion of the volar aspect of the wrist was reported in only four cases. All occurred after 1960. In two other cases, the diagnosis of carpal tunnel syndrome was not made, but the symptom complex is strongly suggestive. In these two cases, there was present a positive Tinel sign, tingling in the radial three fingers, and a ganglion present in the correct location.

No cases in this series apparently caused pressure on other nerves in the hand or wrist, although such phenomena have been reported in other series.

Xanthomas

Xanthomas are benign giant cell tumors of tendon sheath. These occurred in an appreciably older group than did the ganglions, averaging over 50 years of age and (in only two cases) in patients under 30 years of age. The lesions involved fingers in 36 of 38 cases, the index finger of the right hand in over 25 per cent of the cases. This supports the impression that trauma or use is in some way involved. In most other reports, the incidence of cases in men and women has been about equal. I know of no reason why, in our series, women outnumber men about three to one. The number of women was greater than the number of men in our entire series.

The benign giant cell tumor is usually described as a firm, encapsulated mass which frequently appears to encircle a half or three-quarters of the circumference of the involved finger; often it is not discrete.

At surgery, the tumor is often yellowish-gray in color, firm in consistency, with areas showing old hemorrhage or necrosis.

Pain was rarely a complaint in this series. More common was the report of interference with function.

Two recurrences were reported in our series. Apparently only a second operation was necessary in each.

Epidermoid Cyst

Men injure their hands more often than do women. This seems to be the reason that epidermoid cysts occur more often in men. When injury causes implantation of epidermal tissue subcutaneously, a tumor results.

Of the 18 tumors in this series, only two were in patients under 30 years of age, and 13 of the 18 were in fingers.

Pain is a more common complaint in this series than in giant cell tumors, the other large group that occurred in this series, in which the tumors were primarily in fingers. Occasionally x-rays revealed a punched-out area in the underlying phalanx. Obtaining a history of a cutting injury apparently was an aid in diagnosis, but on occasion could not be obtained, probably because of the long latent period between time of injury and the appearance of lesion.

The tumor is a cyst, white in color with a much thicker wall than that of a ganglion. The contents of the cyst are often described as horny debris with a crystalline sheen.

In several of our cases, cauterization of the

lesion or incision and drainage had been done previously in the belief that there was infection present. The treatment of choice is complete excision. With this there was no evidence of recurrence in our series.

Lipoma

Lipomas are uncommon in the hand, and only six cases were seen in this series. The tumor is easy to diagnose in other parts of the body, but in the hand it is harder to identify. The correct preoperative diagnosis was made in only two cases; and in these, the tumor was on the back of the hand where its appearance would be most typical. Tumors at the base of the finger on the volar surface were usually believed to be ganglia or giant cell tumors. One on the ulnar aspect of the wrist was called a rheumatoid nodule.

Other than the difficulty in diagnosis, this tumor seemed to present no problems. Its age incidence was 35 to 61 years.

Glomus Tumors

The three glomus tumors in this series were all in women, whose ages ranged from 33 to 56. They involved thumb, index finger, and a middle finger. Presenting symptom in each case was pain and tenderness in the involved area of a nail bed. The tumors had been present from 2 to 20 years prior to surgery, and had grown only very slowly. Preoperative diagnosis in 2 of the 3 cases was chronic paronychia.

The normal structure from which the glomus arises is an arterio-venus anastamosis, or shunt for terminal vessels which regulates peripheral blood flow. The tumor was usually deep red or purplish color less than one centimeter in size. Pathologically, it is made up of blood vessels with thickened walls and of non-myelinated nerve fibers.

Relief of symptoms after removal of this tumor is often very striking.

Neurogenic Tumors

Only 4 neurogenic tumors were found in this series. Three were traumatic neuromata. One was a schwanoma or neurolemoma, which occurred at the base of a thumb. The neurolemoma produced a burning pain in the thumb, but it was not tender to palpation. At surgery, it was not found related to a nerve. Postoperative course was benign, and there was no return of symptoms.

In one of the traumatic neuromata, it was possible to excise the tumor without interrupting the digital nerve. In the second, excision of the tumor required cutting of the nerves; and resuturing of it was done primarily. In the third, the tumor was merely excised, and no repair was done.

Vascular Tumors

The six vascular tumors in this series included three hemangiomata. One was in a three-year-old child and had enlarged rapidly in the 2 week period prior to surgery. It had been present from birth. This lesion was located in the skin on the dorsum of the hand.

A second hemangioma in the palm in a 62-year-old woman required three attempts before complete extirpation was obtained without recurrence.

A telangiectasia of the tip of an index finger, which had been previously treated with cautery, required skin grafting after excision. Postoperative course was benign.

Malignant Tumors

The eleven malignant tumors in this series are divided into two groups: those arising from the skin and those which were found in the deeper tissues. There were two basal cell carcinomas, one was in a 56-year-old woman and one in a 62-year-old man. Both had been present for a long time prior to surgery. There was no report of difficulty or recurrence after surgery.

Nine squamous cell carcinomas were in patients with an age range from 65 to 95 years; the average age was 75. All the tumors were on the dorsum of the hand. Several, arising primarily in this area, had skin grafting done at time of excision. One squamous cell tumor required a second excision, which was done shortly after surgery because pathologic examination revealed that the entire tumor had

not been excised. This patient was living and well four years later.

Two of the squamous cell carcinomas, however, are of special interest. They occurred in patients who had received x-ray therapy to the involved hand many years prior to the time that the tumors arose. One was in a 79-year-old woman who had had x-ray therapy for swelling of the hand 25 years previously, and had developed burns and dermatitis of both hands. The hands had been treated conservatively by a dermatologist for many years. In an area of chronic infection, skin cancer developed in one hand and required amputation at mid-arm.

The other carcinoma (secondary to x-ray therapy) was that of a 65-year-old woman who had had 25 x-ray treatments 12 years prior to hospitalization. She had developed an undifferentiated squamous cell carcinoma. It had metastasized to the axilla. She also had multiple basal cell carcinomas in other parts of the body. Her weight fell from 160 to 127 pounds at the time of her original surgery at Mountainside Hospital. This surgery consisted of amputation of the fifth finger and adjacent metacarpal area, as well as an axillary dissection. She was readmitted several months later because the lesion had spread to the triceps muscle. The diagnosis was confirmed at biopsy. She was seen 2½ years later, when evidence of further spread of the lesion was found.

Of the three malignant tumors arising in areas other than skin, one was a metastatic tumor which apparently had started as an epidermoid lung cancer in a 60-year-old male. He had metastasis to the soft tissues of the left hand overlying the first metacarpal area. The tumor had been present for two months prior to admission and had enlarged in that time, so it measured 6 by 4 centimeters. It was not attached to the underlying bone. The diagnosis of lung carcinoma had been made one year previously, and at that time there was erosion of several ribs. The hand lesion was excised under brachial block anesthesia. Pathology at this time revealed multiple mitotic figures. The lesion was consistent with that of a metastatic carcinoma of the epidermoid type. He died two months later in cardiac decompensation with evidence of spread of the tumor to the jejunum and intestinal obstruction.

The second case was that of a 56-year-old woman who had had a tumor removed from her wrist 20 years previous to her hospitalization at Mountainside Hospital. Diagnosis was giant cell tumor of the tendon sheath. Shortly before her Mountainside Hospital admission, a new tumor appeared in the area of the old one. This was found to be a liposarcoma, and a supracondylar humeral amputation was done.

Five months later, she was readmitted with a hydrothorax and dyspnea. The pleural cavity was aspirated on two occasions. No malignant cells were found in the fluid. This patient was reported to be alive several months after this surgery, but on a downhill course.

A malignancy with a happier result so far is that of a 13-year-old boy who had a well-defined and localized fibrous tumor excised from between the 3rd and 4th metacarpal heads of the right hand in 1960. The patient had noted the tumors for about six months prior to hospitalization. Report of this lesion was alveolar rhabdomyosarcoma with an element of embryonal rhabdomyosarcoma. Because of the extremely poor prognosis of this lesion, the slides were reviewed by Dr. Arthur Purdy Stout, by the Armed Forces Institute in Bethesda, by the Children's Medical Center in Boston, and at Memorial Hospital in New York. The diagnosis was confirmed by all.

A wide range of therapy was suggested. Amputation was done in the area of the distal forearm. This patient was alive with no evidence of recurrence four years later.

66 South Fullerton Avenue

Thiazide diuretics may reduce potassium and precipitate toxicity in a digitalized patient, as shown here in Dr. Wachtel's unusual case.

Thiazide Diuretics and the Production of Digitalis Toxicity*

Fred W. Wachtel, M.D./Newark

Digitalis is the drug most widely used in congestive heart failure. Precautions in the use of digitalis are mandatory because of the narrow zone between therapeutic and toxic levels. Although these precautions have been repeatedly emphasized, the incidence of digitalis toxicity has increased. This is because we have been recently using drugs other than digitalis. The newer medications include ion-exchange resins, acid and basic salts, mercurial diuretics, hormones, and oral diuretics. All of these can alter the ionic equilibrium in the tissues and body fluids. The response of the myocardium to any given amount of digitalis is altered with any change in the pH and/or ionic equilibrium of the body fluids and tissues. This has been known for many years. The increase in observed digitalis toxicity has not resulted from any change in the drug or patient selection but from the concommitant use of other valuable medications currently employed in the management of congestive heart failure.

In the past several years, a group of oral thiazide diuretics has become available for hypertension and congestive heart failure[1]. In general, they are very effective and without toxic side effects. Thiazides increase the excretion of sodium, chloride, water, bicarbonate, and potassium. The most undesirable metabolic effect of these drugs is hypokalemia[2]. Potassium, of all the electrolytes, has the greatest influence on the heart[3], especially the digitalized heart[4].

The case described below emphasizes the problem of digitalis and thiazide therapy.

A 51-year-old woman was admitted to the Essex County Hospital at Belleville. During the 4 months prior to admission, she had become aware of her heart beating and experienced episodes of weakness. She noted a sense of suffocation. This was relieved by taking deep breaths. There was two-flight exertional dyspnea and occasional ankle puffiness. There was no angina or orthopnea. She was seen at a clinic, and a digitalis preparation (Acylanid®) and a diuretic (Hydrodiuril®) were prescribed. The dosage schedule and amounts actually consumed could not be recalled by the patient. Because her condition did not improve, she saw a private physician. He took an electrocardiogram and suspected digitalis intoxication (Fig. 1A). She was instructed to take no digitalis, but the diuretic was continued. A few days later the electrocardiogram (Fig. 1B) showed an almost complete heart block. The patient was then referred to the hospital.

We found a well-nourished woman in no distress. Blood pressure was 110/60. But her pulse was 48 with definite irregularity. Heart tones were good and no murmurs were audible. Lungs were clear. No signs of congestive heart failure were present. X-ray showed no abnormalities of the heart or lungs. An electrocardiogram (Fig. 1C) disclosed a second-degree heart block with periods of SA block and the Wenckebach phenomenon. Because there were almost no objective evidences of heart disease and only minimal subjective symptoms, it was surmised that the electrocardiographic abnormalities resulted from digitalis toxicity. All medication was withdrawn. Three days later, the electrocardiogram revealed a first-degree heart block with marked ST depressions. Two days thereafter, first-degree heart block was still present, but the PR interval was shorter and the ST depressions had almost disappeared. Six days later, a normal electrocardiogram was recorded. Blood sodium, potassium, and chlorides drawn then were all normal. Reevaluation of the patient before discharge showed no evidence of heart disease.

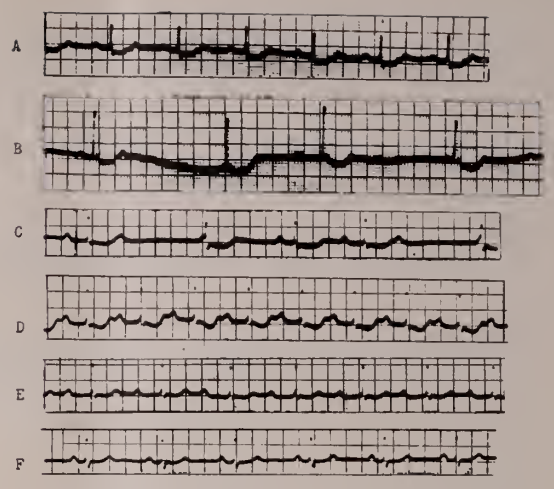
It is not often that one observes the transition over a short period of time of electrocardiograms demonstrating third-degree,. second-de-

*From the Department of Medicine, the Essex County Hospital, Belleville, New Jersey

gree, and first-degree A-V block and normal conduction in the same patient. In this case, these changes were the result of digitalis toxicity. A comment must be made about the transition between tracing A and B, that is from second to third-degree A-V heart block. This represents a worsening of conduction; yet when this change occurred, the patient was not taking digitalis but was continued on the oral diuretic. The latter probably produced a further diminution of potassium, with the net effect of increasing the digitalis toxicity. This has been reported previously by Richman[5].

The first electrocardiogram (strip C) taken two days after admission to the hospital showed only a second-degree A-V block. Serum potassium levels at that time were at the lower limits of normal. It should be pointed out that under certain circumstances serum potassium levels may not truly reflect tissue levels. The improvement over the next several days occurred as the result of the excretion of digitalis and the return of potassium levels to normal.

Digitalis toxicity may occur in even the best of hands and is the result of administering too much of the drug in a specific instance. The concept that digitalis toxicity can occur in an individual without altering a previously acceptable digitalis dosage level is somewhat more subtle. This depends upon an alteration of body electrolytes, primarily that of potassium. The oral thiazide diuretics are very efficacious and widely used. However, they have the ability to reduce body potassium significantly, which in turn may result in toxicity in a digitalized patient.



All strips are standard level 2 of the electrocardiogram. The ST depressions in all strips except F are indicative of digitalis effect.

A. 2: 1 A-V block with an atrial tachycardia of 140 and a ventricular rate of 70.

B. Third-degree A-V block with rare captured beats.

C. Second-degree A-V block with Wenckebach periods and a nodal escape beat.

D. First-degree heart block with a PR interval of 0.32 seconds.

E. First-degree heart block with a PR interval of 0.28 seconds.

F. Normal EKG.

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32 Johnson Avenue

Effects of "More Adequate" Drug Testing

Another approach, and the one now most fashionable, is to call for "more adequate" testing of drugs in animals and humans. Yet, when a drug given to pregnant rabbits results in birth of malformed offspring, it may be unreasonable to rule it off the market. For, under such a policy, the sale of insulin, streptomycin, penicillin, or cortisone might have been forbidden. A recent editorial in *The Lancet* calls attention to this point. Under the latest F.D.A. rulings, aspirin might not be allowed on the market!—J. F. Lucey, M.D., in *Pediatrics*, Dec. 1963.

While alcoholism is a chronic disorder, this does not justify neglecting the acute phase.

Treatment of the Acute Episode in the Chronic Alcoholic*

David I. Canavan, M.D./Franklin Lakes

Perhaps the most important part of the role of the physician in alcoholism is the function he plays in directing the treatment of the acute episode in the life of the chronic alcoholic. All of us in active medical practice are confronted by these patients.

It is important that we have a logical rationale to assure patients of the care to which they are entitled. The rationale here presented is based primarily on the experience of Silkworth at the Knickerbocker Hospital in New York City, where he treated thousands of acutely intoxicated alcoholics. This regime we have followed, with certain modifications, since 1955 at the Mount Carmel Hospital in Paterson in the treatment of almost 9,000 patients.

In certain unusual circumstances, it may be possible to treat milder cases in the home or in the physician's office, provided the doctor can give close personal supervision to the treatment program and provided that a responsible third party (spouse/child/parent/friend/nurse) is in constant attendance to see that the instructions of the physician are carried out.

Environment

The important problem in the period of withdrawal is the patient's compulsive need for alcohol. The easy way out for the alcoholic during this period is to have a "few quick ones," which will eliminate the many unpleasant symptoms associated with withdrawal. For this reason, it is important that, during the withdrawal period, the patient be where alcohol is not. Although it is possible to accomplish this at home under proper circumstances, most physicians intimately concerned with this feel that it is best done in a protected environment. By this we mean an environment in which the patient has no responsibility except to regain his physical well-being, and an environment in which he has no source of alcohol. This milieu is best found in a medical facility. The three types of facilities are:

(1) *Medical Service in the General Hospital*
Unfortunately, in many instances the only available facility is the open medical service or the locked psychiatric ward. Although it is possible to treat the alcoholic under these conditions, there are definite drawbacks. The general nursing staff is often unsympathetic and occasionally openly hostile to the acute alcoholic. There is a failure of the staff to develop concentrated experience with alcoholics. Other patients are often critical and rejecting. The disturbed alcoholic may upset the other patients, and *vice versa*. There is a lack of opportunity for the mutual assistance and encouragement of fellow sufferers.

(2) *Alcoholic Units in the General Hospital*
There has been a considerable interest and a certain degree of success in establishing special units for the alcoholic in the general hospital. These are usually alcoholic wards or services set apart from the rest of the institution. A successful pioneer of this type was the alcoholic unit at Knickerbocker Hospital, where Silkworth did much of his work. A second example is the alcoholic unit at the District of Columbia General Hospital, under the guidance of Schultz.

In these units, an effort is made to attract and train interested personnel. The alcoholic profits from the concentrated experience of the staff of such a unit. In addition, the following services are provided: counselling, rehabilitation

*Read May 19, 1964 at Atlantic City, at the Annual Meeting of The Medical Society of New Jersey.

programs; group therapy and meetings of Alcoholics Anonymous. The alcoholic patient is protected from the embarrassment of the open ward. In many areas such units are the best available means for providing the necessary environment.

(3) *Special Hospital for Alcoholics*

This is an institution established solely for the acutely intoxicated alcoholic. Mount Carmel Hospital is an example of this type of facility. Here the entire operation is dedicated to, and oriented towards, the specific problems and needs of the alcoholic. Its staff members have a deep personal interest in the problem and a sympathetic approach to the victims of this disease. The experience of the staff is valuable in foreseeing and forestalling impending complications. The patient is freed from the embarrassment of the scorn of fellow patients, since all have the same problem. The mutual assistance and camaraderie of the patients is an inspiring thing. This, we think, is the ideal facility. Here the aim is to provide the best available environment consistent with the patient's needs and the means of the community.

Withdrawal

Having decided on the best available setting for our course of treatment, the next step is the total immediate withdrawal of alcohol.

The idea of tapering the patient off is a mistake. It usually serves only to prolong the withdrawal period and its attendant miseries. The severity of symptoms during the withdrawal period is proportionate to the amount and duration of the prior alcohol consumption. There is no evidence that tapered withdrawal will lessen these symptoms.

Sedation

In the treatment of the acute episode, and especially its withdrawal phase, sedation is perhaps the most important consideration.

All of you are familiar with the many unpleasant symptoms associated with alcohol withdrawal. Most of these can be controlled with the judicious choice and use of sedatives. Yet certain inherent problems develop in the use of sedation in the alcoholic.

First, because of his long history of the use of alcohol (which in itself is a sedative agent), the alcoholic has a tremendous tolerance for sedatives. It may take enormous quantities of the ordinarily used agents to achieve the desired degree of sedation. We must be careful that in our desire to quiet an acutely agitated alcoholic we do not inadvertently push him over the brink.

Second, it is all too easy to transfer this patient's need for alcohol into a need for drugs. If we "rob Peter to pay Paul," we have done him a disservice.

Third, at the end of his period of hospitalization, the alcoholic usually has to return to work. If he is kept "snowed under" while he is hospitalized and then allowed to face the effects of drug withdrawal after he leaves the hospital, he has again been done a disservice.

For all of these reasons, we use sedation cautiously. The patient should be given as much as he needs and can safely tolerate on admission. Over the first few days this should be gradually reduced so that on the last two days the patient will get little to no sedation and there will be no need to worry about the effects of withdrawal of sedation on discharge. Four categories of drugs are available:

(1) *The Barbiturates.* These are still one of the most convenient and widely used drugs in this field. The ease of administration, the lack of expense, and the familiarity of physicians with their effects and side effects make them popular.

(2) *The Traditional Hypnotics and Sedatives.* The bromides and chloral hydrate have fallen by the wayside with the increased use of the barbiturates. Nevertheless, they remain effective and useful drugs, especially for short term use in which case toxicity is no problem.

(3) *Paraldehyde.* This old stand-by in the treatment of alcoholism is a useful and effective agent. Its main drawback is that it is basically an alcohol derivative, and in a sense it pushes the patient back to a more comfortable level of intoxication. Thereby it, in effect, prolongs the withdrawal period. There is no equal to this drug in effective control of the extremely agitated alcoholic or the alcoholic in acute delirium.

(4) *The Tranquilizers.* These drugs have made a tremendous impact in the field of sedation.

Although the exact site of their action is not clearly established, there is no question of their effectiveness in going beyond simple sedation in controlling confusion and hallucinatory manifestations. In many of the severely disturbed patients, smooth control may be attained by using these drugs in adequate dosage. The attendant prolongation of the withdrawal phase that may accompany the use of the older agents can thus be avoided.

The choice of a specific tranquilizer will depend on the personal experience of the clinician and the known side effects of the various agents. Our rationale of sedation at Mount Carmel utilizes all of these drugs. We start with a basic regime of phenobarbital administration orally in a dosage of 1.5 grains twice a day, plus a mixture of sodium bromide chloral hydrate for intercurrent and bedtime sedation. All of our patients receive these medications on a decreasing dosage basis over the first three days, unless there is a history of allergy to them. Standard sedation on the fourth and fifth days consists of sodium bromide chloral hydrate at bedtime.

We use the tranquilizers in all patients who manifest agitation or tremulousness. We tailor the dose to each individual patient's needs. It has been our practice to use promazine for this purpose. We prefer promazine because of the less frequent incidence of hypotension and for the excellent clinical results which we have seen in well over 5,000 patients. Dosage varies from 50 milligrams orally four times a day to immediate 200 milligram intravenous doses, depending on the condition of the patient.

Our ace in the hole is paraldehyde. We give it either intramuscularly or intravenously in severely disturbed patients who are not well controlled with promazine.

With this regime we have found adequacy and flexibility in the control of our patients. Patients should get adequate but not excessive sedation. The experience of the clinician will enable him to tailor the dosage to the patient and the degree of his agitation.

Nutrition

Our next important consideration is to correct the nutritional status of our patients. Careful attention to this will accelerate recovery.

The drinking alcoholic, especially during his episodes of compulsive alcoholic excess, consumes enough alcohol to provide all the calories that his body requires to meet the energy needs of the day. Having done this, he has no appetite for the essential food substances that must be present in his diet to maintain good nutrition.

Severe alcoholics are common victims of the whole gamut of the known nutritional diseases. Most of the acutely intoxicated patients admitted to an alcoholic unit like ours show some symptoms of vitamin or nutritional deficiency. The most important therapy in this phase of their problem is to supply a well balanced nutritious diet. Along with this, supplementation with oral and/or parenteral vitamins will accelerate recovery. Silkworth found that thiamine hydrochloride plus nicotinamide was an ideal combination in stimulating appetite and helping restore nutritional balance. Following his lead, we give thiamine hydrochloride 100 milligrams intramuscularly twice a day and nicotinamide 50 milligrams orally twice a day during the entire hospital stay.

The rapid nutritional improvement is gratifying to see. Most of the patients start to eat well on the second day, and weight gains of six to eight pounds in the five day period are common.

Fluid therapy is also important. Unless the patient is vomiting, this can usually be adequately handled with forced oral fluid intake. In rare instances, parenteral fluids may be required. Most patients do well without the use of infusions.

Complications

The commonly seen complications are convulsions and delirium tremens.

Convulsions occur for one of several reasons:

(1) Certain alcoholics are simply epileptic. When they drink, they trigger an ordinary epileptic seizure;

(2) Certain alcoholics react to the withdrawal of alcohol by going into a withdrawal seizure ("The Rum Fit"); and

(3) Cerebral edema (the wet brain syndrome) may lead to convulsions.

The primary objective should be to prevent rather than to treat convulsions. All patients with a history of convulsions should be on anti-convulsant medications. If the patient is an epileptic already on anti-convulsants, these should be continued. If he has a history of withdrawal seizures, the prophylactic use of diphenyl hydantoin and phenobarbital during the first three days will usually prevent seizures. Any patient who shows signs of fluid retention or disturbed fluid balance should be given appropriate therapy with diuretics, magnesium sulfate, or hypertonic glucose. For the unanticipated convulsion, intravenous sodium amobarbital usually will produce immediate control, and the patient can then be continued on anti-convulsant treatment.

Delirium tremens is a self-limited disorder. The patient will ultimately respond even without treatment. It is important to insure adequate food and fluid intake, to provide constant supervision and emotional support, and to use adequate sedation to insure rest and control of tremors and hallucinations. With vigorous sedation, these patients can be put into a profound sleep from which they will usually emerge in a much improved state.

For the control of these patients we use promazine. We give 200 milligrams intravenously as an initial dose and follow-up according to the reaction of the patient. We may repeat 100 milligrams intravenously in one to two hours and then switch to 100 milligrams intramuscularly every four hours until the patient has returned to lucidity or has gone into a deep sleep.

I cannot emphasize strongly enough the need to tailor the therapy to the condition and response of the individual patient. It is in this situation that a trained staff of competent observers is a priceless asset.

The physician who undertakes the care of the acutely intoxicated alcoholic cannot overlook the spectrum of intercurrent medical problems that may demand professional attention while he is handling the withdrawal episode.

Diabetes mellitus, arteriosclerotic heart disease, Laennec's cirrhosis, duodenal ulcer, peripheral neuritis, respiratory infections, and injuries from falls and brawls are some of the more common problems. I once found one of my new admissions with a classical case of measles. I have seen patients with active tuberculosis, intestinal obstruction, brain tumor, and venereal disease, to mention just a few.

The nature of the problem, the degree of contagion of the disease involved, and the adequacy of your facility will determine whether the patient should be kept on the treatment unit.

The Final Phase

The final phase of treatment of the acutely intoxicated alcoholic is preparing the patient for the long term management of his disease. Alcoholism once acquired is a permanent, incurable life-long disease.

There is only one treatment for this disease and that is absolute abstinence.

Because the alcoholic is by nature a dependent person, he usually needs outside help and support in his attempt to maintain complete abstinence.

We feel, at Mount Carmel, that the Alcoholics Anonymous Program is the best available long-term rehabilitation program. As part of our approach to these acutely intoxicated alcoholics, we insist that a member of A. A. sponsor the patient on admission, visit the patient while hospitalized, and agree to follow-up the patient in his early contacts with A. A. after discharge.

We conduct regular A. A. meetings in the hospital for the patients with the idea of introducing or reintroducing them to this program. By doing this, our patients are well oriented towards the A. A. program prior to their discharge. The majority of them continue in the program after discharge.

Whatever the follow-up program is to be, it will be eminently more successful if the introduction is made during the acute treatment episode.

Summary

A review of the treatment of the acutely intoxicated chronic alcoholic has been presented. Emphasis is put on a protected treatment environment, immediate alcohol withdrawal, adequate careful sedation, and nutritional and fluid support. The treatment of the common complications is briefly discussed. The need for orientation during the acute treatment phase to the program intended for long-term management is stressed. The author feels that the best available long-term program is Alcoholics Anonymous.

310 Algonquin Road

Retroactive Drug Clearances Now Required

The American Medical Association advises us that a new Food and Drug Administration regulation requires manufacturers to submit proof of effectiveness of drugs cleared between 1938 and June 20, 1963, if such drugs are still on the market.

The Pharmaceutical Manufacturers Association said the government was "making a mistake in blanketing in drugs which have been regarded as old, safe and effective." The Association added that a retroactive regulation would comprise "such sweeping requests for information as to be unreasonably burdensome on the industry."

"The consumption of manpower, particularly of scarce, highly trained scientific personnel, that would be required to comply with the proposed regulations is staggering and bears no reasonable relationship to any possible benefit to the public," the PMA said.

"In fact the demand on the time of the scientific personnel of our member companies would impede and delay clinical research and the development of new drugs."

Drug manufacturers had argued that "grandfather rights" allowed them to continue to make claims contained in new drug applications cleared in the past; and that they should not now have to produce medical evidence to support these claims. But the FDA retorted that Congress, in passing the drug amendments in 1962, made it the agency's duty to review all medical claims for "new drugs" cleared in the past on safety alone, "with the intention that any claim unsupported by substantial medical evidence should be discontinued after next October."

The FDA added that the "grandfather clause" gives the right to make unsupported claims for only two classes of drugs: (1) those on the market before 1938; and (2) those introduced after 1938 which were generally recognized as safe and were never cleared as "new drugs."

"We are glad that Congress has given us this unique opportunity to review past medical decisions permitting several thousand new drugs to go on the market. This review will include not only a new look at the safety of these drugs, but a first-time comparison of the actual promotional claims with the medical evidence on which they are based," FDA Commissioner George P. Larrick said.

The new regulations require firms marketing drugs approved since 1938 to examine both their promotional materials and their clinical records to be sure that all claims being made are justified by experience and that the promotional materials include all necessary warnings, contra-indications, side effects, and untoward reactions which may have shown up after the drugs were originally placed on the market.

Under the old law, new drugs were cleared on the basis of safety alone. There was no requirement that they be shown to be effective as well as safe for their intended uses, other than that claims of benefits be supported.

LETTER TO THE JOURNAL

Medical Education in New Jersey

The following letter from Dr. Brodkin was received in THE JOURNAL office on October 15, 1964. The views expressed are, of course, his own. On most of these items the Society has taken no official position. The day after this letter was received, announcement was made that the Legislature favored a plan which, in part, was not unlike Dr. Brodkin's recommendations. That is, the proposal was to keep the medical school operating in Jersey City for the next five years, as a state-sponsored college; and then to merge it with Rutgers — which would mean one, instead of two, state medical schools. The recommendations were silent as to the location of the new, combined school. The matter of compulsory internships in New Jersey was not mentioned in the legislative plan.

Committee reports on our medical school situation are reminiscent of the futile attempt of 1950-52 to establish a medical college in our state. Controversies about the site, control, number, and orientation of the schools may again develop into a statewide argument that will force compromise or a solution of expedience—leading to the loss of a school or to an inadequate or slipshod method of solving the problem.

It is interesting and useful to recall the 1950-52 situation to avoid being booby-trapped by the kind of controversy that proved so frustrating then. The plan was to finance the cost of a medical school through a $25,000,000 bond issue to be repaid by a tax on stock transfers. Was the school to be New Brunswick (academically stimulating), Trenton (the capital—near the great medical center across the Delaware), Jersey City (where a ready-made plant was available and near New York), or in Newark (the State's metropolis with many large hospitals available)? There were heated arguments in favor of each site. At that time, the new Newark City Hospital was in embryo, but we knew it would soon be born. State Senator Clapp was chairman of a legislative subcommittee on this problem, and I suggested to him that the AMA be invited to survey the State and make a recommendation. The AMA's Council on Medical Education then laid down the ground rules for a good medical school, surveyed the proposals, and recommended Newark. They made this choice because of (1) pledges from 5 large Newark hospitals offering their facilities; (2) a promise from the County's Board of Freeholders offering the unique facilities at the three county hospitals—a contagious disease unit (Belleville), a tuberculosis sanitorium (Verona), and the nation's largest county mental hospital (Overbrook); (3) a promise of affiliation with VA facilities at Lyons and East Orange; (4) an agreement from Newark's city fathers that the new City Hospital would be given to the school; (5) a remarkable, sincere, and serious offer of the entire medical staff at City Hospital to resign and give the school administration a free hand in selecting a staff; and (6) a promise by the late, great Harrison Martland to provide the necessary material for teaching purposes.

This was countered by a recommendation from a committee sponsored by New Jersey's Department of Education. They preferred New Brunswick with an affiliation with Rutgers which, at that time, was not yet truly a State University. Two differing proposals were thus made public. This marked the high water mark of the suggested medical school. It fell between the two stools—and we had no school.

The climate now is more favorable. Seton Hall has an on-going medical school, and the State seems prepared to buy it. Rutgers is now a true State University. The vast Newark City Hospital is a reality, and plans are far advanced for Rutgers to open a 2-year school in 1966.

Committees, however, are still with us. The most recent recommendation is to take over Seton Hall, keep it a while in Jersey City, and then move it to Newark to utilize the magnificent facilities at the City Hospital there. One plan would set this up independent of Rutgers, giving us two medical schools. Another would take the Seton Hall unit, merge it with Rutgers, and locate it in New Brunswick. If controversy continues, we may, as in 1952, end up with no medical school, with a poor one, or with a needlessly expensive duplicate facil-

ity. Indeed, it may even be triplicate, for there are suggestions now that New Jersey needs a third medical school—possibly near Camden.

The cost of operating a single medical school is high—staggeringly so for a State that has no sales tax or state income tax to draw on. The cost of operating two (not to mention three) such schools would be crushing.

I propose to meet our medical education problem in this way:

(1) Buy Seton Hall Medical School.

(2) Let Rutgers take over the operation of the medical school, but do not site it in New Brunswick. (Cornell's medical school is not in Ithaca; Harvard's is not in Cambridge—there is ample precedent for this.)

(3) Let Rutgers abandon its plan for a 2-year school and accept the 4-year or 5-year school. (It isn't as easy as it sounds for graduates from the second year to find seats in the third year of a good, favorably located medical school.)

(4) Have a medical school building erected in Newark near the City Hospital.

(5) When it is ready, move the student body from Jersey City to Newark.

(6) By this time, Rutgers will know which of the Seton Hall faculty have the academic stature that would justify their being retained. They should be kept, and the faculty expanded as needed.

Up to this point, my plan provides for an orderly transition. And it prevents the break in the continuity of producing doctors which would occur if Seton Hall suspended operations for some years.

Now, the unique feature of this plan is that it will assure ourselves of a supply of American-trained interns for New Jersey hospitals. Here's how:

(7) No medical student will get his M.D. degree until he has completed an internship in a hospital in New Jersey. The State Board should not examine him until this is assured. As a matter of fact, it might be worth considering an extension of this to all young doctors, regardless of school. Let no one get a New Jersey license until he has had a year on the house staff of a New Jersey hospital. Certainly this should apply to graduates of our State's own medical school.

This 7-point plan would assure continuity of high-grade medical education in New Jersey and guarantee us a supply of American-trained house officers for our hospitals. The doctors who go to school in our state and intern in our state are more likely to stay here to practice than those who seek internships elsewhere.

Let there be no more surveys, study plans, or committee reports. We have had our fill of them. Let us provide funds to buy Seton Hall's medical school, and to build a new school in Newark; let us support Rutgers in its hope of establishing a top-grade school with a research as well as a clinical orientation. We have many pharmaceutical manufacturers here—more, I think, than in any state in the union. In their research operations, they would be glad to support the activities of a State Medical School that would cleave to standards that they—and all of us—could be proud of.

Henry A. Brodkin, M.D.
Newark

Curtailment of Drug Research

The drug manufacturers have been increasing their research and development expenditures steadily year after year by an average of 15 per cent. Forecast for 1962 had been for the same increase. However, when the year was over, the increase amounted to only six per cent. Why was it cut to less than half? Why a sudden slowdown in research? The answer is: Government. As PMA President Austin Smith, M.D., commented in a masterpiece of understatement: "Some curtailment of research activities and a more cautious attitude toward investment in new programs has developed in connection with passage of the 1962 drug amendments."—Editorial in *Western Pharmacy,* September 1963.

BOOK REVIEWS

The Fat Boy Goes Poly-Unsaturated. By Elmer Wheeler. New York, 1963, Doubleday & Company, Inc. Pp. 156. ($3.50)

Here is a humorous, clearly illustrated book written by a layman which tells the cholesterol story in non-medical language. Each chapter is prefaced by an epigram, such as: "There's nothing wrong that less animal fats won't cure —Feeder's Digest." His answer to a recent widely advertised book advocating fighting fat with fat is: "It seems foolish to get a snake to bite you to cure the snakebite of another snake."

The author relates his own experience in reducing his cholesterol level, but stresses that it was done under medical supervision. This is not meant to be a medical text nor does it attempt to resolve the question of what is accomplished once the cholesterol level had been reduced. It was written to make people cholesterol conscious. Harvey P. Einhorn, M.D.

The Blight on the Ivy. By Richard E. Gordon, M.D. and Katherine Gordon, M.A. Englewood Cliffs, New Jersey, 1963, Prentice-Hall. Pp. 301. ($4.95)

Too many college students are getting into trouble—suffering neurotic or psychotic outbreaks; dropping out; underachieving; getting psychosomatic disabilities. Almost 3 per cent of the suicides are committed by teenagers. What's wrong?

Dr. Gordon, a New Jersey psychiatrist, and his wife, a social psychologist, here offer the fruit of their research. They find that many college freshmen had inadequate guidance in high school; that many are caught up by the anxieties and tensions that, they feel, are destroying the previous placidity of the campus and college town. The text material is salted by vividly written case histories. Most of these, indeed, are so interesting that the reader develops anxiety wondering what will happen next. Some may object to the way in which the Gordons emphasize what's wrong with college without ever saying that some things are right. However, this is a study of blight, and one would not expect a textbook of pathology to give many chapters to healthy tissue. The Gordons deliver their message in crackling, punchy language. Some may call this a pandering to unsophisticated tastes. But the authors never talk down to the reader; indeed, if the wings they give to their words will attract readers and make them think of the problem, I would say "more power to the authors."

The book closes with practical suggestions about meeting the problems so well described in the text. Descriptions of the emotional disorders involved do ring true and do give the public a usable concept of what we mean by acute psychotic episodes, antisocial psychopaths, deep introverts, rebels, empty-headed extroverts, well-meaning incompetents, and teachers who sacrifice depth for breadth. The gallery of characters profiled here will give the non-psychiatric reader a lot more insight into these classifications than he will get from a solemn textbook. Henry A. Davidson, M.D.

The Pathogenesis of Leprosy. Edited by Gordon Wolstenholme, M.A. Boston, 1963, Little, Brown and Company. Pp. 101, illustrated. ($2.95)

The Ciba Foundation is again to be thanked for having published the most modern concepts concerning a very ancient disease. The causative organism was discovered by Hanson in 1873. For the present, the disease leprosy is acquired only after persistent and repeated contact with an infected individual. There are so-called leprosy houses in the islands near New Zealand; people who live in these houses get leprosy suggesting that the bacillus can survive indefinitely. It is interesting to recall that a similar doctrine was propounded by the elder Dr. John Flick in Philadelphia many years ago concerning "tuberculosis houses." For this doctrine he was "roundly roasted" at that time by the regular medical profession.

Murine leprosy, because of the ease with which the disease can be reproduced in experimental animals and of certain similarities to human leprosy infection, has been used in experimental studies. Bacilli divide only every 10 to 14 days. This long generation time is unique for micro-organisms, even for mycrobacterium where the generation time for the tubercle bacillus is 20 to 24 hours. This relatively long generation time has been utilized to explain the incubation period of human leprosy, which is known to be two years or longer.

The bacillus of murine leprosy can be maintained in continuous multiplication within rat fibroblast cells for well over 500 days. Shepherd has been able to bring about a multiplication of human leprosy bacilli in footpads of mice. The multiplied organisms show Mitsuda reactions closely parallel to those given by standard human lepromin. The treatment of leprosy has been rather standardized by the use of diaminodiphenylsulphone.

If the reader is interested in the disease of human or murine leprosy, this small volume is recommended reading.

Thomas K. Rathmell, M.D.

Handbook of Pediatrics. By Henry K. Silver, M.D.; C. Henry Kempe, M.D.; and Henry B. Bruyn, M.D. 5th edition. Los Altos, California, 1963, Lange Medical Publications. Pp. 602. ($4)

It is fair to rate this compendium as a "Best Buy". Though the authors modestly describe it as a "mere supplement" for more complete pediatric texts, the average reader will find it of greater practical value than many works of greater size, cost, and scope. It is natural to compare it with Dr. Davison's *Compleat Pediatrician*. I find it easier reading. The facts are obtainable in both, but annoying terseness and the odd pagination and cross references are avoided in this handbook.

As a confirmed nit-picker I question the occurence of "brawny" as opposed to gelatinous edema in mumps; and neither I nor otologists of my acquaintance accept the statement that in otitis media "continuous drainage in spite of adequate antibiotic therapy indicates that an external otitis has developed from the discharge." I am happy to find that myringotomy is declared "usually not necessary."

Adequate consideration is given to laboratory procedures, immunization, and electrolyte management. Dr. Kempe is well known for his studies in antibiotics, and the chapter concerning these is excellent. I regret that he does not exercise his authority more dogmatically in discussing the "don'ts" of antibiotic therapy, especially concerning chloramphenicol.

The only chapter that I find disappointing is the one on emotional problems by Dr. Ruth Kempe. It is not the author's fault. Fifteen pages permit merely a smattering of platitudes that will help little in general practice.

On the whole, the suggestions are conservative and the line drawings, many charts, and tabulations well presented. It should be in the reference library of all pediatricians and family doctors.

George Heller, M.D.

Clinical Gastroenterology. By Eddy D. Palmer, M.D. Revised. Ed. 2. New York, 1963, Harper & Row. Pp. 706. ($22.50)

Few authors today undertake the task of writing an entire medical text alone. Dr. Palmer has done this and produced a satisfactory work. Obviously, however, such a broad subject is likely to introduce differences of opinion.

The author includes congenital shortening as a cause of esophagitis although, later in the text, admits that this is rare. I believe it is so rare that it should be omitted. Invariably, the shortening that occurs in reflux esophagitis is acquired. Clinical and anatomic differences between sliding, paraesophageal, and combined hernias are incomplete. The indications for surgery and the complications of herniorraphy are inadequately discussed. However, the author laudably emphasizes the high incidence of recurrence following surgery. Adequate discussion of peptic ulcer of the esophagus is also absent.

The chapter on achlorhydria is good. On the other hand, the statement that "gastroscopy re-

mains the best method for the diagnosis of chronic gastritis" must be seriously questioned. The author does mention that gastroscopy should be supplemented by biopsy. Most gastroenterologists will admit that biopsy is the only reliable method for such a diagnosis. Dr. Palmer's emphasis on the emotional problems of the patient and pyschosomatic therapy in the treatment of peptic ulcer is appreciated, but I know of no significant studies that indicate that pyschosomatic disease initiates peptic ulcer althought it may aggravate it. I seriously question the author's belief that adenomatous as well as hyperplastic regenerative polyps of chronic ulcerative colitis are disposed to cancerous change. The former may very rarely be true; the latter, never.

A. I. Friedman, M.D.

The Nurse and Her Problem Patients. By Gertrud Bertrand Ujhely. New York, 1963, Springer Publishing Company, Inc. Pp. 180. ($2.85)

With a direct human approach to common nurse-patient relationship problems, the author attempts to present maneuvers used by the practitioner to allay the patient's anxiety. The use of both hypothetical and real situations gives the reader a concrete and pragmatic approach to direct interpersonal relationship technics. These assist the patient in describing experimental material and allow the nurse to observe and therepeutically intervene in situational problems outlined in the various chapters.

The author projects patterns of understanding and appreciation for recurring experiences and themes which will increase the nurse's effectiveness as a therapist and assist her in formulating a nursing diagnosis for each patient, problem or not. Both patient and nurse may introspectively examine their behavior and arrive, it is hoped, at some meaningful goals and adjustments during the stress periods of illness and hospitalization.

This vital book challenges the nurse practicing in any interpersonal situation. The manner of presentation is lucid and terse. The material outlined is basically for the nurse, but the other health disciplines will find it of value, as it depicts another important role of the nurse, one who allays anxiety in the patient.

The author has contributed greatly to the nursing literature by the publication of this treatise. William H. Nace, R.N.

Books Received

The Dream World of Dion McGregor. New York, 1964, Bernard Geis Associates. Pp. 214. ($3.95). Tape recordings of a sleep talker; apparently unedited and certainly uninterpreted.

Smoking, the Great Dilemma. Ruth Brecher. Public Affairs Pamphlet 361. New York, 1964, Public Affairs Committee. Pp. 28 (one copy 26¢; lower prices in quantity). A practical and readable explanation of the hazards of smoking, free from cant and moralizing.

Modern Treatment: (1) Treatment of Anemias; (2) Treatment of Arrhythmias. Part of the new series of books, two topics bound in a paperback, released monthly, but available only on an annual subscription of $16.

Infectious Diseases of the Cornea and Conjunctiva. New Orleans Academy of Ophthalmology. St. Louis, 1963, Mosby. ($12.50). Pp. 230. Texts of 18 papers on the indicated subjects, followed by 40 pages of verbatim discussion.

Corneal Contact Lenses. Staff of Baylor University College of Medicine. St. Louis, 1964, Mosby. Pp. 342. ($19.75). A practical treatise on all aspects of the prescription and fitting of contact lenses

Synopsis of Pathology. W. A. Anderson, M.D., St. Louis, 1964, Mosby. ($9.75). Pp. 882 with 405 illustrations Edition 6. A new edition of this 20-year old, compact, reliable and readable synopsis of clinical pathology.

Dynamic Pathology. M. M. Black, M.D. and B. M. Wagner, M.D. St. Louis, 1964. Mosby. Pp. 296. Illustrated. ($8). A departure from the traditional dead-house pathology, with emphasis on continuity, homeostasis and the concept of disease as functional derangement.

An Outline of Urology. C. D. Creevy, M.D. New York, 1964, McGraw-Hill. ($7.95). Pp. 385. A flexible-backed, medical student's compend of this surgical specialty.

ABSTRACTS

ON TUBERCULOSIS AND OTHER RESPIRATORY DISEASES. ISSUED BY THE NATIONAL TUBERCULOSIS ASSOCIATION

NOVEMBER, 1964 • VOL. XXXVII, NO. 9

ABNORMALITIES OF RESPIRATORY FUNCTION IN VARICELLA PNEUMONIA

Alveolar-capillary gas exchange was abnormal in acute varicella pneumonia when measured in adults during or after chickenpox infection. There was no evidence of ventilatory impairment.

While the seriousness of primary varicella pneumonia is recognized, information concerning the physiological alterations of this disease is lacking. Dyspnea, cyanosis, and tachypnea are often present and contrast with the few findings on physical examination of the chest.

The diffuse nodular pulmonary densities and prominent bronchovascular markings seen on X-rays are similar to the changes of sarcoid, miliary tuberculosis, and carcinomatosis. Cyanosis, diffuse nodular pulmonary infiltration, and hyperventilation, in combination, point to impairment in alveolar-capillary gas exchange.

Since there is no precise definition of the functional abnormalities of primary varicella pneumonia, the present study was undertaken to determine the character of the respiratory defect, its extent, and duration.

Study Composition

In the study were 17 adults hospitalized with varicella and 4 persons with histories of chickenpox in adult life. Ten of the 17 patients showed the characteristic X-ray changes of primary varicella pneumonia, while 7 had normal radiographs. Ten patients with other acute diseases but with normal cardiopulmonary examinations served as controls.

Alveolar-capillary gas exchange of the chickenpox patients was assessed at rest and, if possible, at exercise, by measurement of the steady-state carbon monoxide diffusing capacity (DL_{CO}). Arterial blood was sampled; oxygen saturation, carbon dioxide content, and pH were measured; and carbon dioxide tension calculated. Measurements of ventilatory capacity were obtained as soon as the patients were no longer contagious.

Functional Findings

Nine of the 10 patients with varicella pneumonia complained of cough, and minor hemoptyses occurred in 3. Five patients reported dyspnea but it was severe in only one.

The mean values for the maximum breathing capacity and vital capacity were within normal limits for 9 patients with varicella pneumonia, 4 with histories suggestive of varicella pneumonia, and 4 with varicella without pneumonia. The highest mean maximum breathing capacity (123 per cent) was obtained in the acute varicella pneumonia group. The lowest mean values for both maximum breathing capacity (107 per cent) and vital capacity (96 per cent) occurred in the patients with histories suggestive of acute varicella pneumonia. No evidence of airway obstruction was found in any individual.

Jose S. Bocles, M.D.; N. Joel Ehrenkranz, M.D., and Asher Marks, M.D. *Annals of Internal Medicine,* February, 1964.

All patients with acute varicella pneumonia had impaired carbon monoxide diffusion at rest as well as at exercise. Diffusion studies on the subjects with histories of respiratory embarrassment during chickenpox were also impaired at rest and exercise but to a lesser extent than the acute varicella pneumonia group. The mean resting results for varicella patients without pneumonia were identical to the controls. However, measurements of exercise diffusion in 3 patients with varicella without pneumonia were somewhat reduced.

Arterial oxygen saturation in the varicella pneumonia patients did not differ greatly from the controls. Patients with acute pneumonia showed the greatest degree of hyperventilation as judged by pH and carbon dioxide tension values.

Diffusing Capacity

In general, resting and exercise diffusing capacity measurements improved with time. In 3 patients resting values returned into the normal range between the first and third months. In the others, normal resting values were not obtained over an observation period of 4 to 13 months. Exercise values reveal more scatter and 4 patients show an apparent reduction in diffusing capacity at some time during the period studied.

The subjective complaint of dyspnea did not correlate with the results of diffusion measurements. The individual with the least diffusion impairment complained of dyspnea while the patient with the most did not.

A significant diffusion defect in acute varicella pneumonia was demonstrated. Only 3 of 7 patients with acute varicella pneumonia returned to the control range of resting diffusion capacity in the period of observation and in only one did the exercise capacity become normal. Data obtained in patients with histories suggestive of varicella pneumonia indicate impairment may persist for eight years.

Few physiological investigations of viral pneumonias have been reported and the occurrence of abnormalities in gas exchange is not widely appreciated. In a recent study of a variety of viral pneumonias other than varicella, diffusion abnormalities similar to those of the present study were found during the acute phase and in a six-month follow up.

No Ventilatory Impairment

An increased venous admixture was found in many patients during the acute illness. It decreased during the convalescent period. Data from the present study do not permit quantitative assessment of shuntlike pulmonary blood flow although the arterial oxygen saturation on breathing oxygen for 15 minutes did not rise as high in 8 patients with varicella pneumonia as it did in 4 control subjects.

The question of obstructive ventilatory insufficiency as a cause of respiratory distress may be raised.

Wheezing respirations and prolongation of the expiratory phase in more than 50 per cent of patients with varicella pneumonia have been reported, but airway obstruction was not confirmed. In the present series one patient was found to have expiratory wheezing, but the ventilatory studies in this subject indicate no evidence of an obstructive defect. Thus, little objective evidence exists for ventilatory impairment in acute varicella pneumonia.

New Jersey Tuberculosis and Health Association

15 East Kinney Street, Newark 2, New Jersey

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PRO-BANTHĪNE (propantheline bromide) Assures Authoritative Anticholinergic Control in Gastrointestinal Dysfunctions

The clear and consistent therapeutic benefits of Pro-Banthīne (propantheline bromide) have made it the preferred anticholinergic for the past decade.

During that time, many compounds have been developed and proposed as alternatives. In the appraisal of Roach[1] ". . . few, if any, have seemed to offer a distinct improvement, . . ."

Early investigations showed that Pro-Banthīne (propantheline bromide) reduces motility and acid secretion and may be used in a wide range of dosage, to bring prompt, positive anticholinergic benefits to patients with peptic ulcer, spastic colon, pylorospasm and related gastrointestinal dysfunctions.

Recent evaluations sustain these earlier judgments. In a current authoritative assessment based mainly on the factors of potency, superiority to atropine, clinical experience and physiologic study, Steinberg and Almy[2] select as the first two preferred anticholinergic drugs, methantheline [Banthīne] and propantheline [Pro-Banthīne].

The name Pro-Banthīne (propantheline bromide) sets a stamp of therapeutic authority on any anticholinergic prescription.

Side Effects and Precautions—Urinary hesitancy, xerostomia, mydriasis and, theoretically, a curare-like action may occur. The drug is contraindicated in patients with glaucoma or severe cardiac disease.

Dosage—The usual adult dosage is one tablet of 15 mg. with meals and two at bedtime; this amount may be doubled or tripled for patients with severe conditions. Pro-Banthīne (brand of propantheline bromide) is supplied as tablets of 15 mg. and, for parenteral use, as serum-type ampuls of 30 mg.

SEARLE
Chicago, Illinois 60680
Research in the Service of Medicine

1. Roach, T. C.: Therapy of Peptic Ulcer, J. Louisiana Med. Soc. *115*:136-139 (April) 1963.
2. Steinberg, H., and Almy, T. P., Drugs for Gastrointestinal Disturbances, Chapter 21, in Modell, W. (editor): Drugs of Choice —1964-1965, St. Louis, The C. V. Mosby Company, 1964, p. 343.

PEPTIC ULCER • FUNCTIONAL HYPERMOTILITY • IRRITABLE COLON

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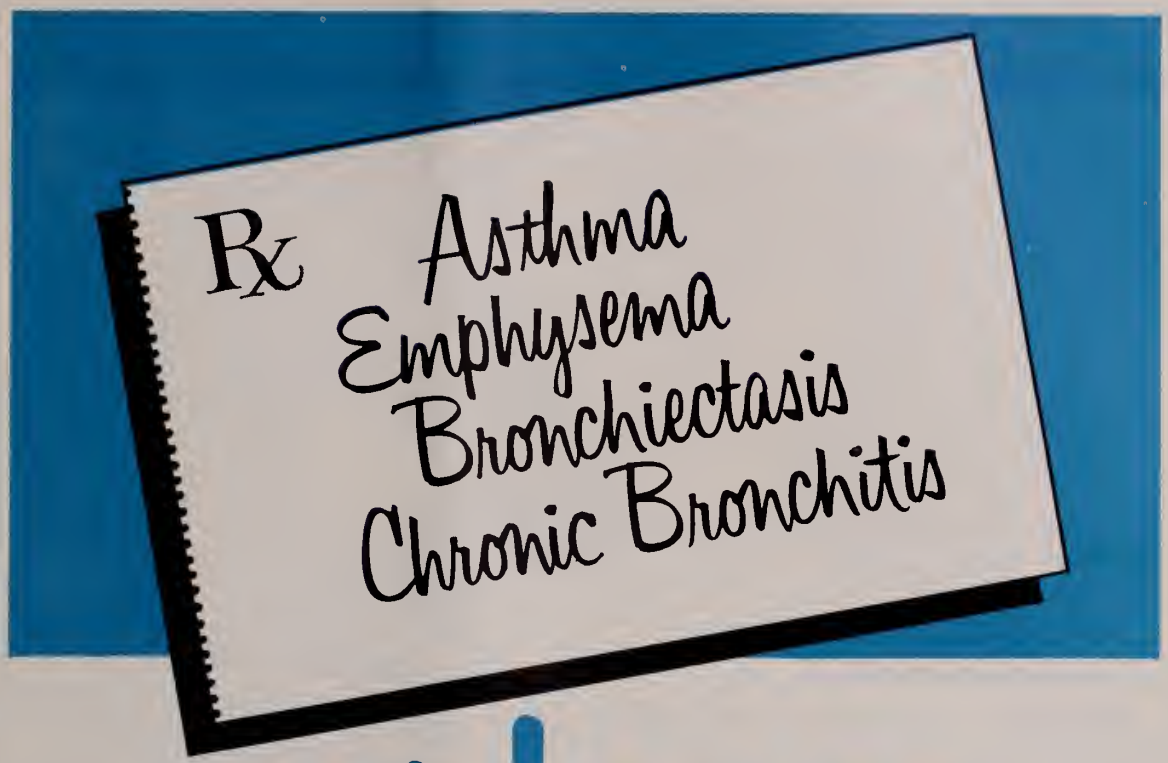
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The Bronchodilator with the intermediate dose of KI

The fast-disintegrating, uncoated tablet gives relief to the asthmatic in 15 minutes. The ephedrine-phenobarbital balance eliminates nervousness. It relaxes broncho-constriction, liquefies mucus-plugging and is buffered for tolerance.

Each tablet contains Aminophylline 130 mg., Ephedrine HCl 16 mg., Phenobarbital 22 mg. (Warning: may be habit-forming), Potassium Iodide 195 mg. Dosage: One tablet, 3 or 4 times a day. Precautions: Usual for aminophylline-ephedrine-phenobarbital. Iodides may cause nausea, and very long use may cause goiter. Iodide contraindications: tuberculosis, pregnancy. Issued in 100's, 1000's.

Also available as

mudrane® GG

Formula is identical to Mudrane except that Glyceryl Guaiacolate 100 mg. replaces the Potassium Iodide as the mucolytic expectorant. Issued in 100's and 1000's.

and

mudrane® GG ELIXIR

The formula of four teaspoonfuls Elixir equals one Mudrane GG tablet. Dosage 6 to 12 years: One to two teaspoonfuls 3 or 4 times a day. Under 6 years, adjust dosage according to age. Issued in pints and half gallons.

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Therapeutic amounts of B and C in stress formula vitamins often are vital during periods of physiologic stress. STRESSCAPS, designed to meet increased metabolic demands, aids in achieving a more comfortable convalescence, a more rapid recovery. After surgery, as in many stress conditions, STRESSCAPS vitamins are therapy.

Each capsule contains:

Vitamin B_1 (Thiamine Mononitrate)	10
Vitamin B_2 (Riboflavin)	10
Niacinamide	100
Vitamin C (Ascorbic Acid)	300
Vitamin B_6 (Pyridoxine HCl)	2
Vitamin B_{12} Crystalline	4 mc
Calcium Pantothenate	20

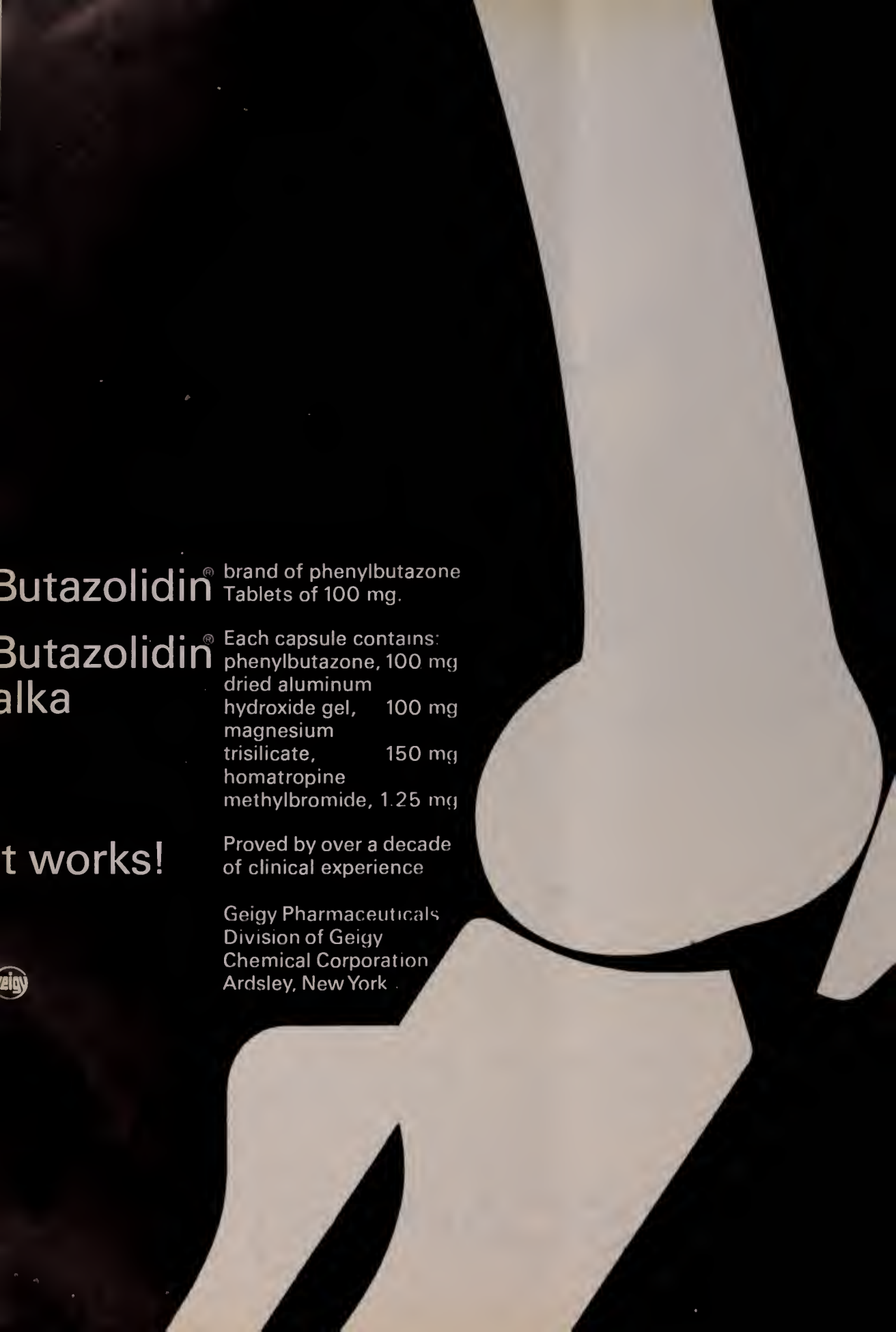
Recommended intake: Adults, 1 caps daily, for the treatment of vitamin ficiencies. Supplied in decorative " minder" jars of 30 and 100; bottles of 5

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brand of phenylbutazone
Tablets of 100 mg.
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Dimetapp® Extentabs®

(Dimetane® [brompheniramine maleate], 12 mg.; Phenylephrine hydrochloride 15 mg.; Phenylpropanolamine hydrochloride, 15 mg.)

In sinusitis, colds, U.R.I., Dimetapp lets your "stuffed-up" patients *breathe easy again.* Each long-acting Extentab provides clear relief for up to 10-12 hours, yet seldom causes drowsiness or overstimulation.

BRIEF SUMMARY: ***Indications:*** Dimetapp reduces nasal secretions, congestion, and postnasal drip for symptomatic relief of colds, U.R.I., sinusitis, and rhinitis. ***Side Effects:*** In high dosages, occasional drowsiness due to the antihistamine or CNS stimulation due to the sympathomimetics may be observed. ***Precautions:*** Administer with caution in the presence of cardiac or peripheral vascular diseases and hypertension. ***Contraindications:*** Antihistamine sensitivity. Not recommended for use during pregnancy.

*Clinical report on file, Medical Department, A.H. Robins Co., Inc.

A.H. ROBINS CO., INC., RICHMOND 20, VA.



THE ULCER LIFE

In this "pop art" assemblage, artist Bob Sullivan depicts "the ulcer life" as man-in-a-box. The wall of nails closing in might well symbolize the torturous demands of a rigid, conformist society. As for the man, his disembodied psyche moves relentlessly onward with the blank, fixed stare of a man who has lost control of his own destiny. Small wonder that his gastric mechanism rebels.

NUMBER 1 IN A SERIES

for the ulcer life:
a new strength of glycopyrrolate

ROBINUL® FORTE
2 mg. per tablet

ROBINUL®-PH FORTE
glycopyrrolate 2 mg. phenobarbital 16.2 mg. (warning: may be habit forming)

When glycopyrrolate was first introduced, clinicians were immediately impressed by the remarkable ability of this compound to exert a more specific pharmacologic action on the gastrointestinal tract than on other organ systems. For example, they often found that in difficult patients the dosage could easily be adjusted upwards to achieve the desired suppression of both hypertonicity and secretion . . . without paying the penalty of side effects intolerable to the patient. Thus, it is no surprise that many clinicians suggested that a double-strength 2 mg. tablet of glycopyrrolate would be both practical and useful. For those patients ordinarily unresponsive to anticholinergics or for those exhibiting the more prominent symptoms, the new Forte dosage forms are a worthwhile addition to your ulcer armamentarium.

BRIEF SUMMARY

INDICATIONS: In addition to its primary indications for duodenal and gastric ulcer, glycopyrrolate is indicated for other G-I conditions which may benefit from anticholinergic therapy. Robinul-PH Forte (glycopyrrolate 2 mg. with phenobarbital) is indicated when these situations are complicated by mild anxiety and tension.

CONTRAINDICATIONS: Glaucoma, urinary bladder neck obstruction, pyloric obstruction, stenosis with significant gastric retention, prostatic hypertrophy, duodenal obstruction, cardiospasm (megaesophagus), and achalasia of the esophagus, and in the case of Robinul-PH Forte, sensitivity to phenobarbital.

PRECAUTIONS: Administer with caution in the presence of incipient glaucoma.

SIDE EFFECTS: Dryness of mouth, blurred vision, urinary difficulties, and constipation are rarely troublesome and may generally be controlled by reduction of dosage. Other side effects associated with the use of anticholinergic drugs include tachycardia, palpitation, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, drowsiness, and rash.

DOSAGE: Should be adjusted according to individual patient response. Average and maximum recommended dose is 1 tablet three times a day: in the a.m., early p.m., and at bedtime.

See product literature for full prescribing information.

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Clinical Meeting: Philadelphia, **Nov. 28 - Dec. 1**
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Clinical Meeting: Las Vegas, Nevada, **Nov. 27 - Dec. 3**
1967 — Annual Meeting: Atlantic City, **June 18 - 22**

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SPANSULE®

brand of sustained release capsules

controls appetite all day long with a single morning dose

relieves the emotional stress that causes overeating

Brief Summary of Principal Side Effects, Cautions and Contraindications

Side effects (chiefly nervousness and insomnia) are infrequent, and usually mild and transitory.

Cautions: 'Eskatrol' *Spansule* capsules should be used with caution in the presence of severe hypertension, advanced cardiovascular disease, or extreme excitability. There is a possibility, though little likelihood, of blood or liver toxicity or neuromuscular reactions (extrapyramidal symptoms) from the phenothiazine component in 'Eskatrol' *Spansule* capsules.

Contraindications: Hyperexcitability, hyperthyroidism.

Before prescribing, see SK&F Product Prescribing Information.

Supplied: Bottles of 50 capsules.

1. Dorfman, W., and Johnson, D.: *Overweight Is Curable*, New York, The Macmillan Company, 1948, p. 16.

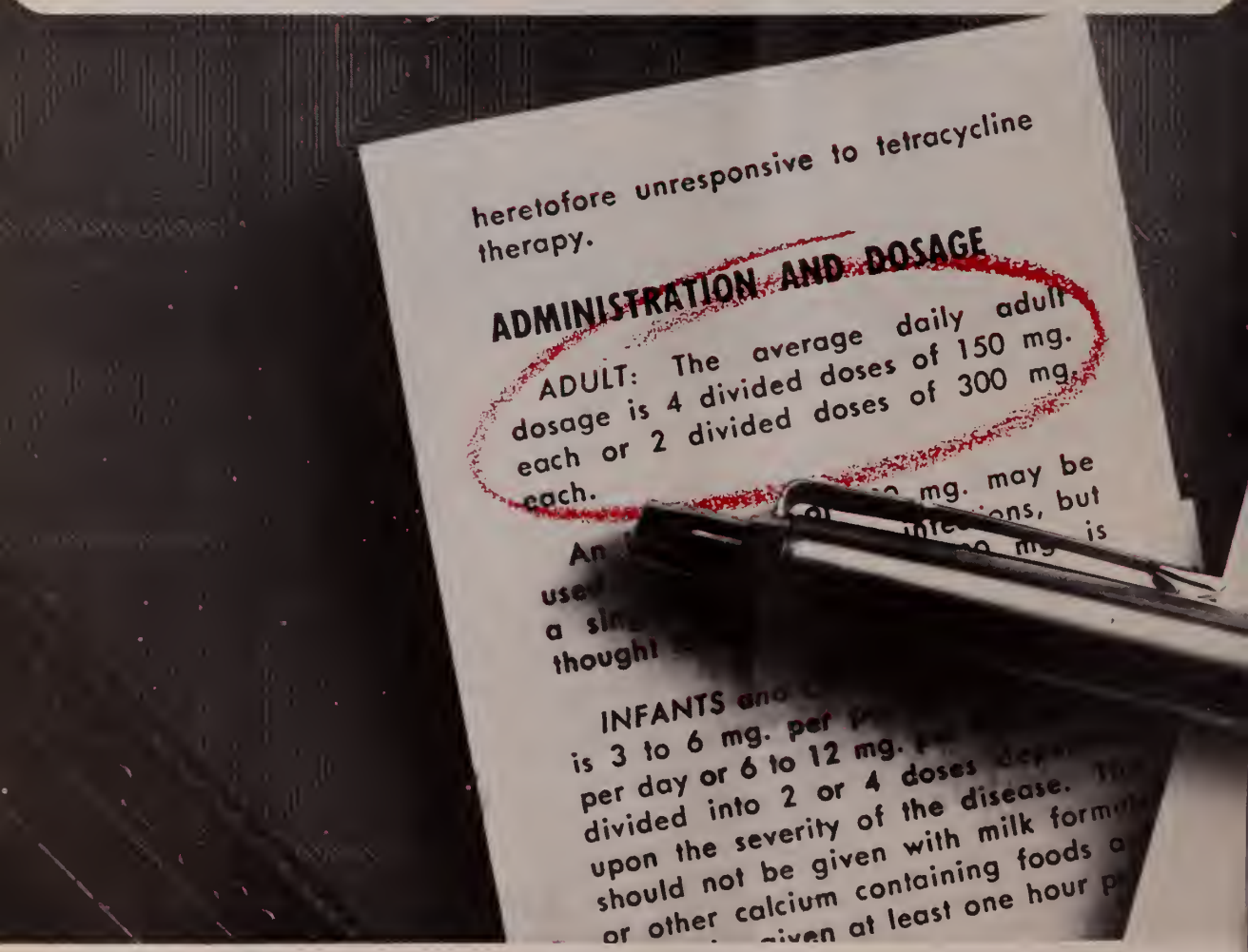
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Doctor, may we remind you of this special option for

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DEMETHYLCHLORTETRACYCLINE

150 MG. CAPSULES

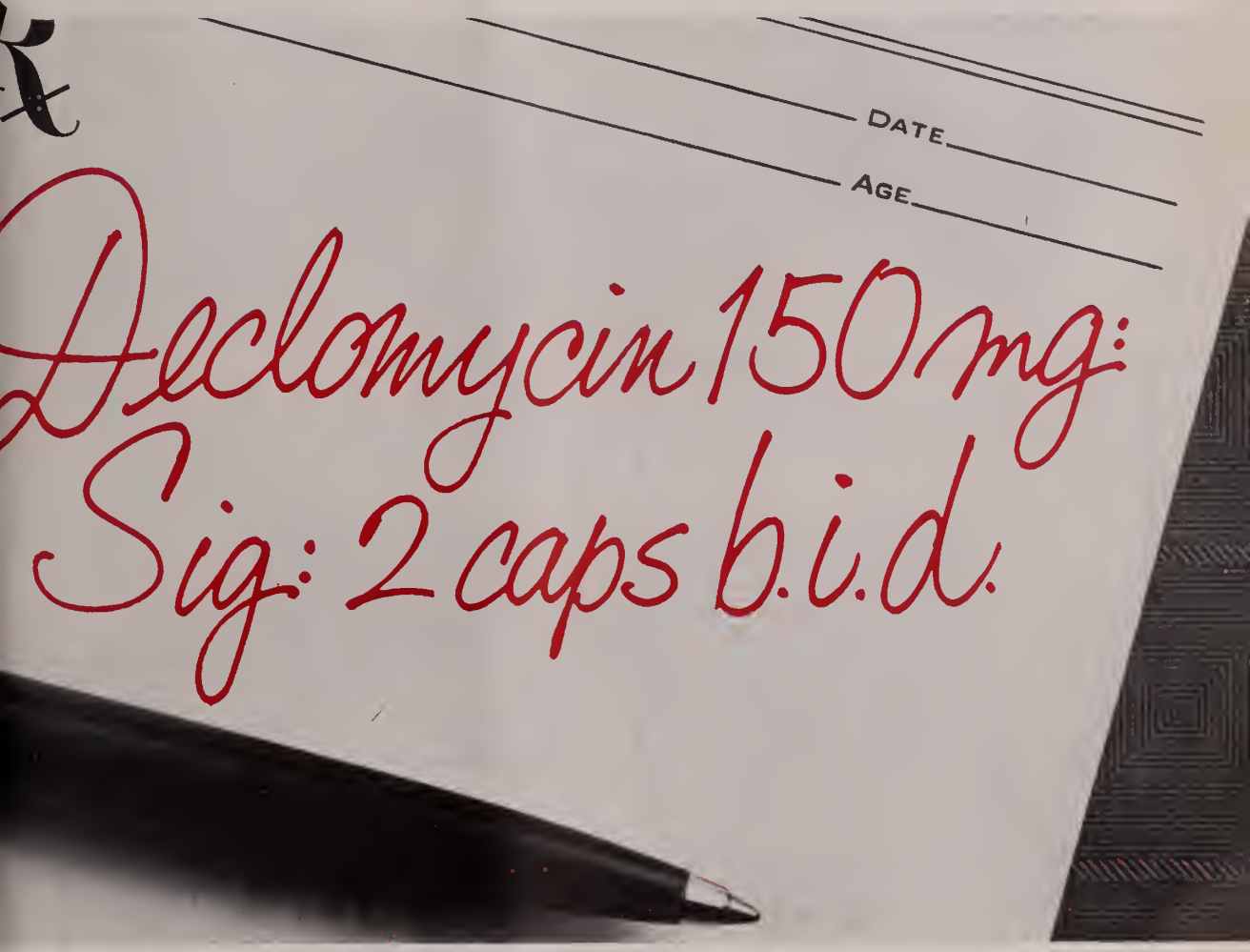


the "extra" benefits of DECLOMYCIN® permit b.i.d. dosage:

☐ for added assurance of optimum response ☐ less risk of "skipped" doses ☐ sustained activity levels throughout the night ☐ high initial levels ☐ reduces chance of mealtime interference when given between meals ☐ as well tolerated as q.i.d. dosage

extra convenience for the patient

...especially for the 34 to 62 patients out of a hundred who "skip" doses[1,2,3,4]



Effective in a wide range of everyday infections—respiratory, urinary tract and others—in the young and aged—the acutely or chronically ill—when the offending organisms are tetracycline-sensitive.

Side Effects typical of tetracyclines which may occur: glossitis, proctitis, nausea, diarrhea, vaginitis, dermatitis, overgrowth of nonsusceptible organisms. Also: photodynamic reaction (making avoidance of direct sunlight advisable) and, very rarely, anaphylactoid reaction. Reduce dosage in impaired renal function. The possibility of tooth discoloration during development should be considered in administering any tetracycline in the last trimester of pregnancy, in the neonatal period, and in early childhood.

Capsules, 150 mg. and 75 mg. of demethylchlortetracycline HCl.

Average Adult Daily Dosage: 150 mg. q.i.d. or 300 mg. b.i.d.

References: 1. Schwartz, D.; Wang, M.; Zeitz, L., and Goss, M.: Medication Errors Made by Elderly, Chronically Ill Patients. *Amer. J. Public Health* 52:2018 (Dec.) 1962. 2. Dixon, W.; Stradling, P., and Wootton, I.: Outpatient P.A.S. Therapy. *Lancet* 11:871 (Nov. 2) 1957. 3. Curtis, E.: Medication Errors Made by Patients. *Nurs. Outlook* 9:290 (May) 1961. 4. Mohler, D.; Wallin, D., and Dreyfus, E.: Studies in the Home Treatment of Streptococcal Disease. *New Engl. J. Med.* 252:1116 (June 30) 1955.

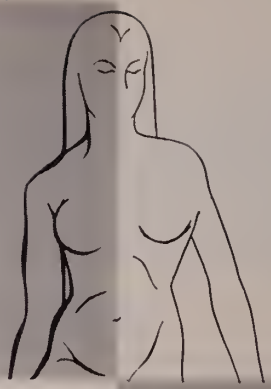
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(Levamfetamine Succinate)



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Each **CYDRIL** (levamfetamine succinate) Granucap* contains:
levamfetamine succinate 21 mg.
(Releasing the drug over a 6-10 hour period)

Each **CYDRIL** (levamfetamine succinate) Tablet contains:
levamfetamine succinate 7 mg.

Side Effects: Rare—C.N.S.** stimulation minimal, occasionally cardiovascular and gastrointestinal reaction may be observed.
Contraindications: Severe hypertension, angina pectoris, hyperthyroidism and Raynauds disease.

Available:
GRANUCAPS*—Bottles of 100, 1000
TABLETS—Bottles of 100, 500, 1000
Request clinical samples and literature on your letterhead.

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1-Doy October 7, 1964
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October 21 to December 16, 1964
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2-Doys October 30, 31, 1964
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Ethisterone . . . 10.00 mg. Ethinyl estradiol . . . 0.01 mg. per tablet

Supplementing and supporting ovarian function, DUOSTERONE can help release your patients from the anxiety, discomfort and inconvenience of functional amenorrhea, dysmenorrhea, and dysfunctional uterine bleeding.

Periodic progestational treatment with DUOSTERONE aims at restoring the normal hormonal pattern of the secretory phase of the menstrual cycle, providing an orally active progestogen with an estrogen to prime the endometrium for adequate progestational response.

Dosage: Functional amenorrhea, 5 tablets daily for 5 days. Dysmenorrhea, 1 to 2 tablets daily during the second half of the menstrual cycle, except for the final two days. Dysfunctional uterine bleeding, 5 to 7 tablets daily for 5 days; in mild cases, reduce dose 1 tablet each day.

Side Effects: Ethinyl estradiol may occasionally cause headache, diarrhea, engorgement and tenderness of the breasts, nausea, vomiting, cramping, or skin rash. These side effects usually fade as the patient adjusts to the estrogen.

Cautions and Contraindications: DUOSTERONE is contraindicated in carcinoma of the breast and reproductive organs and should be used with caution in cases of known liver impairment.

Supplied: Bottles of 25 and 100 tablets.

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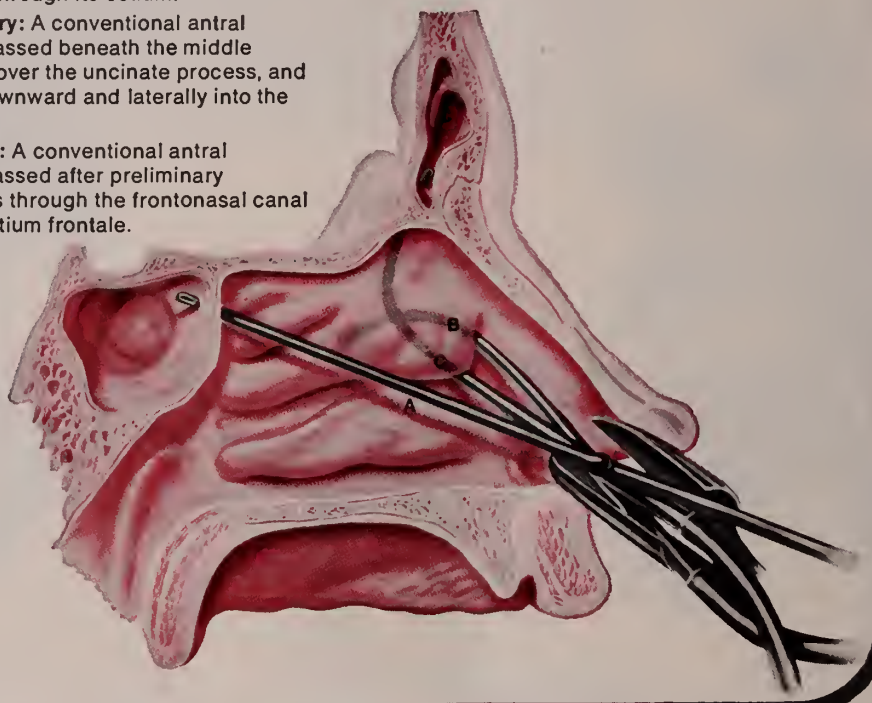
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A rhinologic approach to the sinuses
Sagittal anatomical section of nasal cavity showing approach for probing or irrigation by cannulas.

A—Sphenoid: A sphenoid cannula (under 13.5 cm.) passed around the middle and superior turbinates to the anterior wall of the sinus through its ostium.

B—Maxillary: A conventional antral cannula passed beneath the middle turbinate, over the uncinate process, and rotated downward and laterally into the ostium.

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In colds and sinusitis

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(Brand of phenylephrine hydrochloride)

can help prevent emergency measures later

Before complications arise in colds and sinusitis, Neo-Synephrine solutions and sprays reduce nasal turgescence on contact — to promote essential aeration and drainage. Turbinates shrink, sinus ostia open and drainage is freed. Relief is instant and the threat of complications is lessened.

In the treatment of sinusitis, the ¼ per cent solution is a preferred vasoconstrictor, "...most closely approximating physiologic composition with the least 'rebound' tendency...."* Gentle Neo-Synephrine is well tolerated by delicate respiratory tissues. Systemic effects are practically nil, post-therapeutic turgescence is minimal and repeated applications do not lessen its effectiveness. Neo-Synephrine has been a standard among vasoconstrictors since 1935.

Available in plastic nasal sprays for adults (½%) and children (¼%), in solutions of ⅛, ¼ or 1 per cent.

*Reed, G. F.: Sinusitis, New England J. Med. 267:402, Aug. 23, 1962.

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GENERAL PRACTITIONER WANTED—Outstanding opportunity in college town for above-average man with minimum 2 years' experience. Salary to start; partnership end of one year. Write Box No. 141, c/o THE JOURNAL.

GENERAL PRACTITIONER WANTED—Young well-trained physician to join busy and growing practice in suburban New Jersey. Mostly medicine and pediatrics; some obstetrics and minor surgery. Beautiful new building. No investment required. Up to $18,000 for the right man. Early partnership. Write Box No. 120, c/o THE JOURNAL.

HOUSE PHYSICIAN—ECFMG or state licensure, 155 bed accredited, general hospital; 32 miles Philadelphia, $9,600 plus benefits. Apply Administrator, Salem County Memorial Hospital, Salem, New Jersey.

INTERNIST—33, board certified, completing year of cardiology fellowship at Children's Hospital, Boston (Dr. Nadas), seeking association, part-time cardiology preferred. Cardiac catheterization experience. Available July 1965. Write Box No. 144, c/o THE JOURNAL.

SALARIED POSITION—Young general practitioner in Camden area desires part-time position in office, industry, or institution. Write Box No. 103, c/o THE JOURNAL.

WANTED—Additional specialists for new medical office building in New Jersey suburbs of Philadelphia, currently housing 9 medical and dental specialists. Ideal location for radiologist, otolaryngologist, dermatologist, medical laboratory. Write Box No. 143, c/o THE JOURNAL.

HOME-OFFICE FOR SALE—Union. Six-room living quarters. Well-equipped four room basement office. General practitioner twenty-five years. Terms. MU 8-3308, Tuesday and Thursday.

FOR SALE—Custom built rancher, u-shaped, built in 1955, brick and stone. One wing office space, 4 rooms each 8′ x 10′, one room 8′ x 13′, lavatory, x-ray processing room, and small business office. L-shaped home, wing-front porch, lawn sprinkler system, 3 bedrooms, 2½ baths, kitchen with dinette, dining-room, living room, family room, large utility room, and enclosed back porch. Gas hot water heat—3 zones. Built for comfort and convenience. Presently used as a dental office and home. Best spot in beautiful Margate, perfect for physician with growing family. No parking problems, near all houses of worship, schools, and shopping. On bus line. Present owner must retire due to ill health. A rare buy! Write or call Dr. Gabriel Reiter, 8204 Ventnor Avenue, Margate City, New Jersey 08402; phone 609-822-2796.

HOME-OFFICE FOR SALE—Active general practice. Office fully equipped. North Jersey shore, excellent location. Price reasonable. Contact Mrs. Clare E. Stalcup, 267 Lawrence Avenue, Oakhurst, New Jersey, 07755.

FOR SALE—Picker x-ray machine, century 100, fluoroscope, accessories. Reasonable. Call FU 8-2800.

OFFICES FOR LEASE—Now renting new air-conditioned, customized offices, near new hospital construction. Community Medical Arts Building, West Maple and Church Street, Bound Brook, New Jersey. Write Box No. 139, c/o THE JOURNAL.

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FOR RENT—Morris County. Suite in new Rockaway Professional Center. Ideal for GP. Air-conditioned. Two hospitals in immediate area. Off street parking. Dentist in occupancy. Call OA 7-2186.

FOR RENT—Suite in small professional building, street floor, air-conditioned, off-street parking, centrally located in South Orange. Suite #1—730 square feet; Suite #2—430 square feet. AD 3-1901.

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Information for Advertisers—RATES: $5.00 per insertion up to 25 words; 10 cents each additional word. Payable in advance. **WORD COUNT:** Count as one word all single words, two initials of a name, each abbreviation, isolated numbers, groups of numbers, hyphenated words. Count name and address as five words, telephone number as one word, and "Write Box No. 000, c/o THE JOURNAL" as six words. **COPY DEADLINE:** Fifteenth of preceding month.

REVISED LIFE INSURANCE POLICIES

Our life insurance plan, through our accredited agents (E. & W. Blanksteen), has been revised, and in this connection, Mr. Blanksteen has sent us the following communications.

The following improvements have been incorporated into the Nationwide Life Insurance Company's policy:

The privilege of renewing the policy to the policy anniversary date next preceding the 70th birthday even though the last renewal might be for less than a full five year period. Prior to this revision, the policy could not be renewed for any five year term commencing after the attainment of age 65. For example, previously a policy issued at age 31, 36, 41, 46, etc., had to terminate at 66; one issued at age 32, 37, 42, 47, etc., had to terminate at 67, and so on. Now ALL may continue to the anniversary prior to age 70.

If premium is being waived under the five year term policy, such premium will continue to be waived to the policy anniversary next preceding the 70th birthday and at that time conversion to a permanent form of insurance will take place with the premiums on the conversion policy being waived during continuance of total disability.

The new policy does not require the return of the policy to the home office for informal renewal at the end of any five year term at expiry.

The divided option on the revised plan has eliminated the "accumulate at interest" election, which very few applicants selected.

The Nationwide Life Insurance Company has designed a special policy endorsement to permit renewals to the anniversary date next preceding age 70 for those policyholders presently participating in your program.

We maintain for the coming year the increased dividend structure which was announced to your membership in 1963.

NOVEMBER IS LIFE MONTH

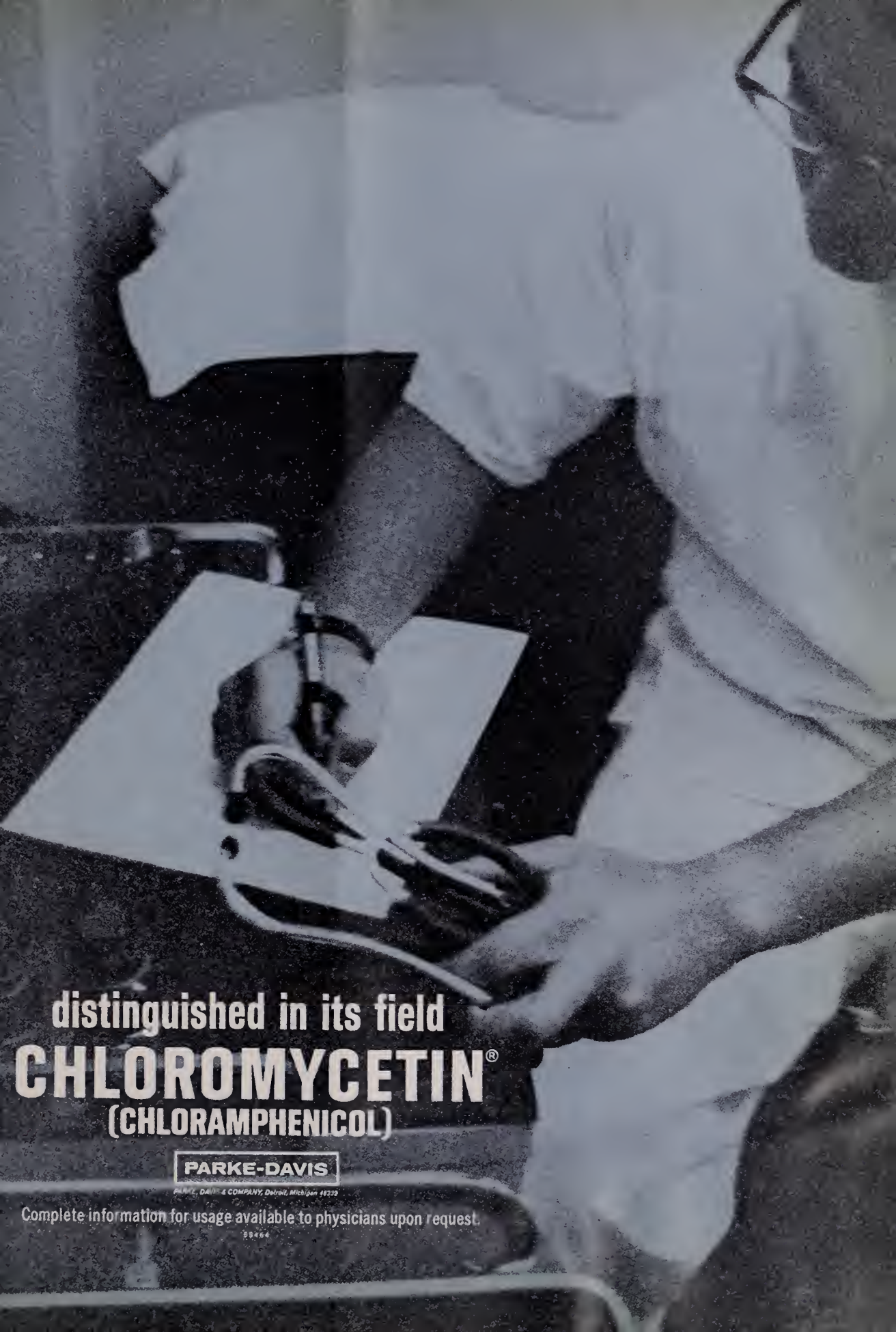
"Life Month," for the life insurance plan endorsed by our State Society since 1959, begins November 1 and ends November 30. During this month, members under age 65 who are not yet covered by the plan may apply—subject to company approval of their applications—for from one to five $10,000 units providing a maximum term insurance coverage of $50,000. These policies include double indemnity for accidental death and a waiver of premium benefit.

At present, over 1,700 members participate in the program and claim benefits to beneficiaries exceed $750,000 to date. Insured members may apply to increase their present coverage to the term insurance maximum of $50,000, subject to a physical examination at company expense by a local examiner. Members who have converted previously issued term policies may apply for new term insurance up to the $50,000 term insurance maximum.

A new feature has been added to our program. Term insurance may now be continued to the policy anniversary prior to the 70th birthday, at which age protection is continuable through conversion. This new renewal privilege will also apply to previously issued term policies that are now in force. The valuable conversion privilege in the policy has been exercised by many policyholders during the past year, to obtain permanent life insurance on a guaranteed issue basis without physical examination or evidence of insurability. Our Society's life insurance plan has lower premiums than comparable policies obtained individually, and may be retained even if you retire or move from the state.

Last year's dividend scale is being continued, and the dividends have been announced for all policies renewing prior to December 31, 1965. The dividend is $25 per $10,000 unit for those ages 35 and under; $16 for those 36 through 40; $10 for 41 through 50; $6 for 50 through 60. This dividend scale will apply to currently issued policies at their first annual renewal.

Members will receive complete information during "Life Month" from the administrator, E. & W. Blanksteen Agency, 75 Montgomery Street, Jersey City, New Jersey 07302. They will welcome your calls for information at Delaware 3-4340 area code 201; call collect, if you wish.


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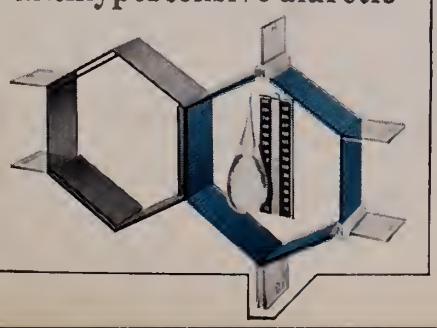
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1. Steigmann, F., and Griffin, R.: Evaluation of Quinethazone, a New Diuretic. J. Amer. Geriat. Soc. 11:945 (Oct.) 1963.

2. Schwartz, M.: Office Evaluation of a New Diuretic in Patients with Hypertensive Diseases. Scientific Exhibit Presented at the Clinical Meeting of the American Medical Association, Los Angeles, California, Nov. 25-28, 1962.

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1. Faludi, G.: J. Am. Med. Women's Assoc. 18,722, 1963. 2. Weller, et al.: Scientific Exhibit, A.M.A., June 1962.

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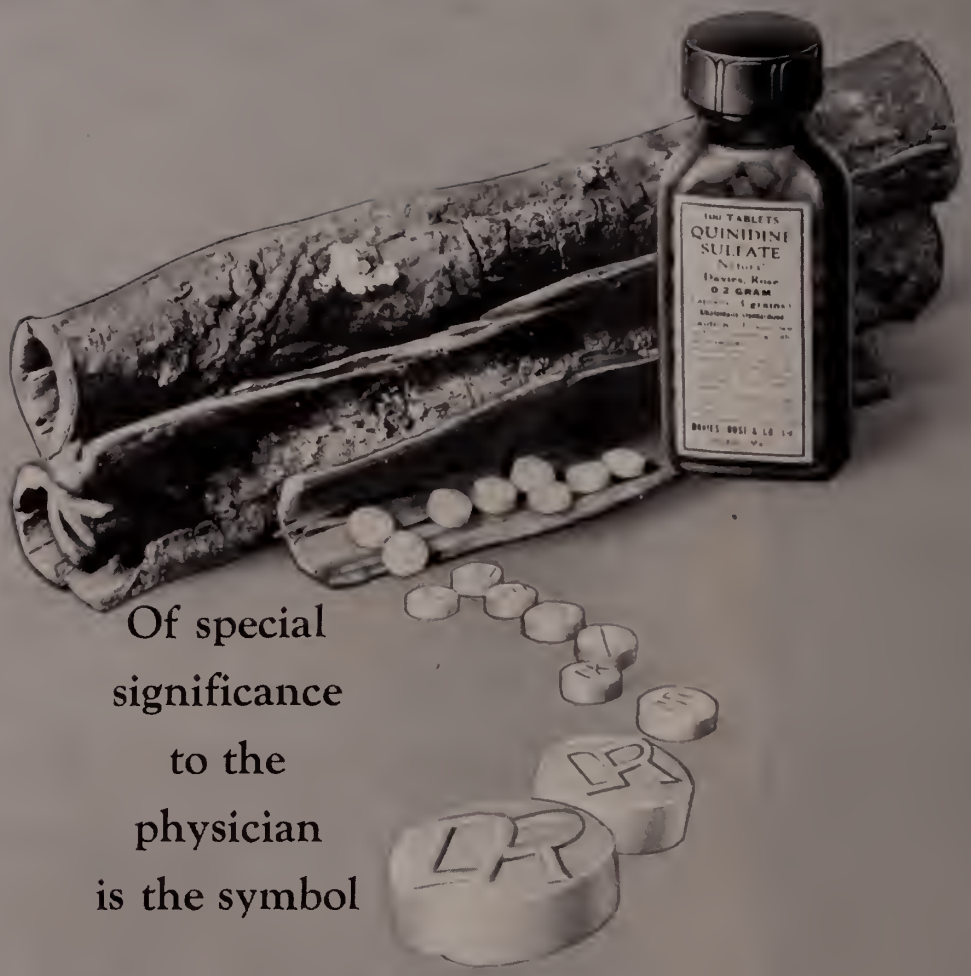
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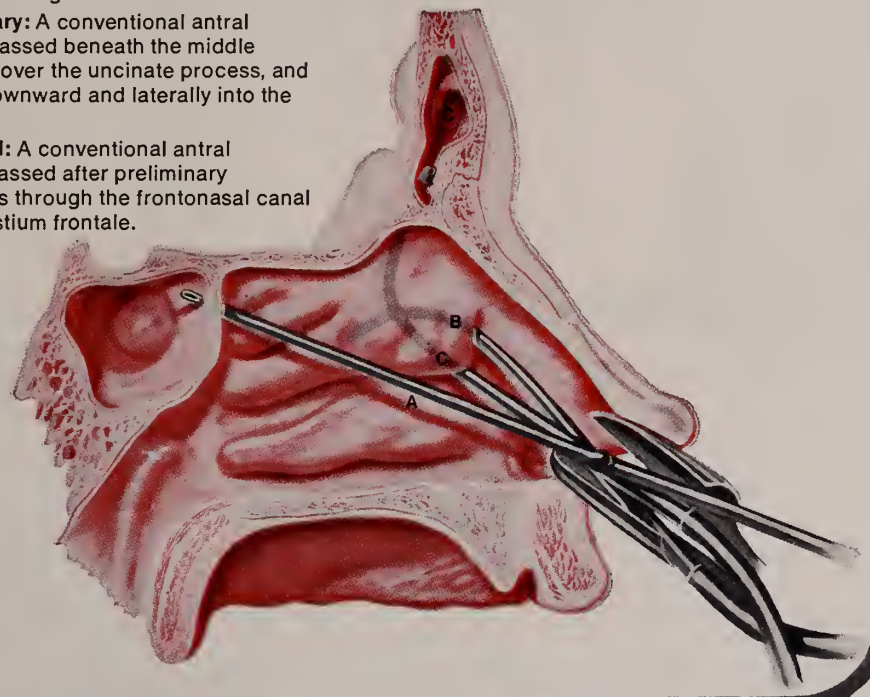
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* AMA Council on Foods and Nutrition: The Regulation of Dietary Fat, *JAMA* 181:411-423 (August 4, 1962).
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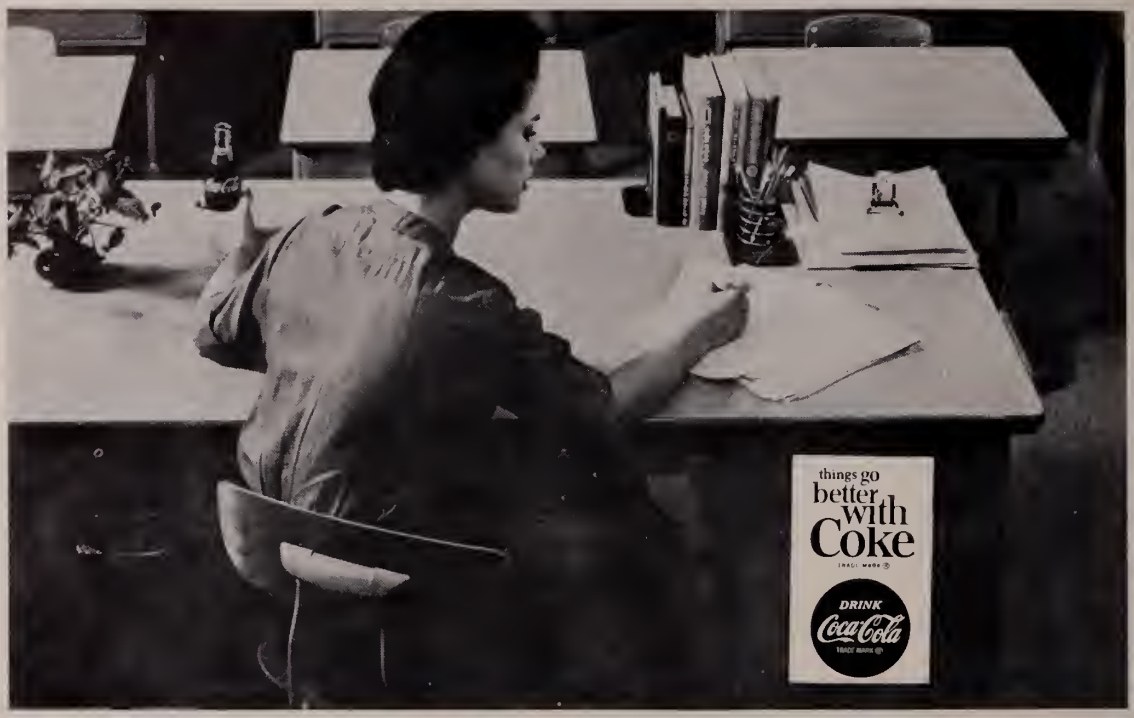
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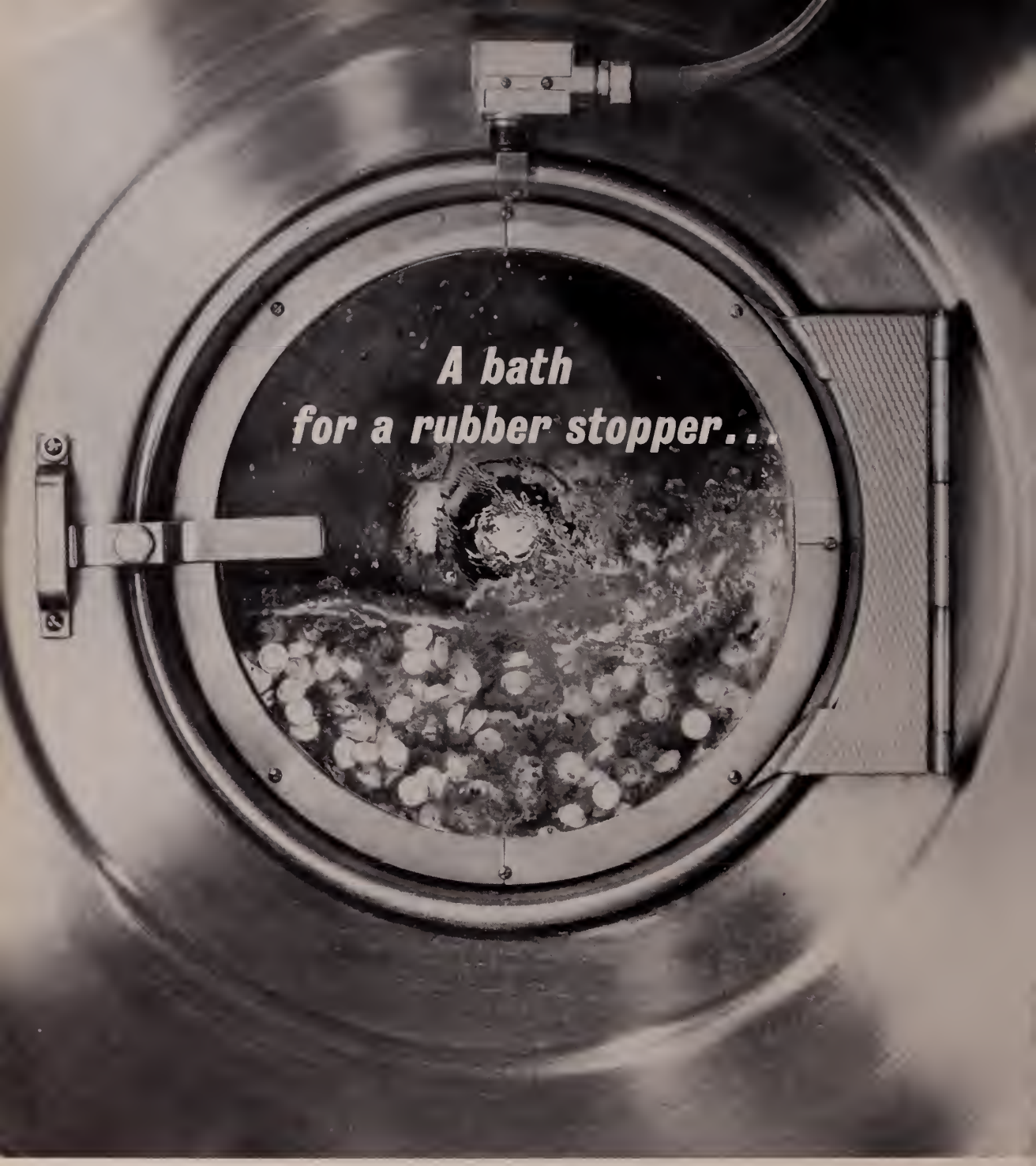
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EDITORIALS

Those Cheerful Little Seals

Last year, some 3,000 new cases of tuberculosis were turned up in New Jersey. More than half were "active"—requiring medical care and/or hospitalization. In our small state, at least 15,000 citizens now have active pulmonary tuberculosis. Obviously, then, this disease is far from being licked. To be sure, the change in the past half century has been spectacular. The national death rate (per hundred thousand) was 184 at the turn of the century; today it is 5. But the rate of fall has been getting slower, and it has hovered around 5 or 6 for some years now.

The dramatic drop in the death rate has been due to the devoted work of physicians and other medical scientists; to progress in many phases of science; and also, let it be said, to research, public education, and to developing social services for the tuberculous and their families. In the latter segments—research, social services, and education—the voluntary agencies, like New Jersey's own Tuberculosis and Health Association, have been pioneers.

For 58 years, the prime source of the funds (needed to fuel this education-and-research program) has been the sale of Christmas seals. That time is here again. No doctor should let December mail escape from his "out" basket without its share of the colorful seals.

The Vanishing Oath

To most of us—at least in your editor's generation—the solemn and moving high spot of the doctor's career was the moment when the class stood up; and with grim or beaming faces, intoned the Oath of Hippocrates. It seemed appropriate that the transition from Mister to Doctor should be symbolized by something more than a hand shake and the transfer of a piece of paper. The occasion called for gravity. An incantation of almost liturgical quality seemed just right. The Oath symbolized crossing of the bridge into a kind of priesthood—and this too was part of our heritage. No matter if some of the wording of the Oath seemed archaic. It had style and it told the public that, like the priest, we were sworn to solemn vows. "He wouldn't reveal what I told or what he found," the patient would say safely, "because that would violate his Oath."

So it was with something of a shock that we learned[1] that, out of 96 U. S. A. and Canadian medical schools, only seven administered the classical Oath of Hippocrates. Indeed, even including these seven, only 21 of the 96 gave any variant (classical or modern) of the Hippocratic Oath. Not a single one of the 12 excellent Canadian medical schools still uses the traditional form[1].

To be sure, an analysis (semantic not psycho-) of the Oath shows some obsolete concepts. It opens with "I swear by Apollo and by all the gods and goddesses . . .". And possibly this would be considered pagan, maybe sacrilegious by good Christians, Jews, and Moslems. Then, too, the original Oath makes students promise to share substance with their teachers and to teach the art to their teachers' children[2]. Since medical schools today (by contrast with the situation 30 or 40 years ago) usually pay salaries to senior clinical faculty, it is necessary for them to violate this part of the Oath. Nor can modern practitioners assume the responsibility for financially supporting their old teachers.

The pledge against lithotomy is, of course, one major criticism of the Oath. Indeed, one

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[1]Irish, Donald, and McMurry, Daniel: "Utilization of Professional Oaths." This appeared in *Research Previews* (11:5) for February 1964. It is a publication of the Institute of Social Science, University of North Carolina, Chapel Hill. The items in this editorial marked (1) come from this carefully prepared and thought-provoking essay.

[2]In the Adams translation: ". . . to share my substance with him, to relieve his necessities, to look upon his offspring as my brothers, and to teach them without fee or stipulation." The translation given in both Stedman's (Williams and Wilkins) and Dorland's (Saunders) dictionaries is: ". . . to share my goods with him, to look upon his children as my own, and teach them without fee or written promise."

translation[3] suggests that the proscription was against *all* surgery (then considered a subspecies of barbering) and that a literal translation would be "I will not use the knife, not even to cut persons laboring under the stone." Most versions, however, are to the effect that "I will not cut for stone."

The pledge of confidentiality is also open to criticism. Actually, it is a bit vague. In one form it reads, "all . . . which ought not to be spread abroad, I will keep secret"; or "whatsoever ought not to be spoken of abroad" or in some translations, "all which should not be noised abroad." But what does the "ought" mean? Ought the fact that a school bus driver is an epileptic be kept secret? If the law requires you to report gun shot wounds, are you violating the Oath?

One of the modernizations of the Oath (the University of Ohio form) opens not with an oath to Apollo, but with "I swear by whatever I hold sacred." This should satisfy anyone[4] except, perhaps, those who hold nothing sacred. The Ohio variant deletes references to financial obligations to teachers and omits the ban on lithotomy. Its language is less quaint than that of the classical form. Irish and McMurry[1] find that 14 of the 84 reporting schools in the U. S. A. use this Ohio (or some other modernized) version; only 7 use the classical Oath of Hippocrates.

An increasingly popular replacement is the Declaration of Geneva. This opens with the phrase "I solemnly pledge." The first promise is "to give my teachers the respect which is their due," which relieves the doctor of any obligation to teachers who deserve nothing. He also promises to "treat my colleagues as my brothers" (which should please the carriers of liability insurance) and "to respect secrets confided to me." The unique feature of the Declaration of Geneva, however, is this: "I will not permit considerations of religion, nationality, race, politics, or social standing to intervene between myself and my patient."[6] The Declaration of Geneva grew out of the trials of some Nazi physicians who performed acts of brutality on human beings. In addition to the standard defense of "obedience to orders," there was the added defense that they had never promised to accept the human beings entrusted to them as "their patients" and were, indeed, under no legal or moral obligation to do so.[6]

As of 1963, eleven U. S. A. medical schools administer the Declaration of Geneva[1] instead of the traditional Hippocratic Oath. Only 7 offer the classical Oath. The number of schools which have replaced it with the Declaration of Geneva is slowly increasing.

There is some evidence that the public views doctors, as a group, with less enchantment than they did a half century ago; that the layman sees the physician more as a successful business man and less like a dedicated clergyman. Of course, the slow atrophy of the traditional Oath is not the cause of this; but it could be a symptom.

Hippocrates wrote some aphorisms as well as an Oath. The first aphorism was: "Life is short; art is long; the occasion, fleeting; experience, fallacious; and judgment, difficult." It still is.

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[3]Victor Robinson in *The Story of Medicine* (Boni, New York, 1931) uses the broader translation: "I will not use the knife, not even to cut persons laboring under the stone." The two dictionaries (Dorland and Stedman) have it: "I will not cut for stone even in a patient in whom this disease is manifest." Adams translates it: "I will not cut persons laboring under the stone." The available American edition of the Adams translation is in "The Genuine Works of Hippocrates," Baltimore, 1939, Williams and Wilkins. The author is Francis Adams, M.D., LL.D.

[4]What do people hold sacred? The Latin word for witness—for one who swears by all he holds sacred, to tell the truth—is *testis*. This, of course, is also the Latin word for testicle. The same root, *testis*, appears in testimony, testament, testify, and attest. Conceivably (if that is the right adverb) the ancient Roman held as most sacred his sexual organs, and so he swore by them; or perhaps this echoed the Greek custom that only a *man* could take a credible oath, and he had to show intact testes to prove his manliness. Some classicists say that when the male Greek testified, he placed his hands on his scrotum, not on any Book; and thus swore by that part of his anatomy which he held most sacred.

[5]Apparently this began with a set of principles on the use of human subjects as experimental animals. In the trial of the 23 Nazi physicians, the Allied Military Tribunal used this code as a basis. Shortly thereafter, the World Medical Association suggested that the vanishing Hippocratic Oath might be replaced by one which took this problem into consideration. The British Medical Association in 1946 urged a codification of our profession's attitude toward war crimes by physicians. In 1948, the World Medical Association adopted what it called "A New Charter of Medicine" which, by the following year, had won considerable acceptance as the Declaration of Geneva.

[6]In the current AMA Principles of Ethics, section 5 opens with: "A physician may choose whom he will serve."

ORIGINAL ARTICLES

The physician's optimism can buoy up the patient and help him improve. And even in presumably hopeless cases, there is always a chance. Here are three examples.

There Is Always Hope

Victor Siegel, M.D./Red Bank

As physicians, we must always remain optimists. Here are three case reports of conditions we consider hopeless: (1) Hodgkins Disease (2) Adenocarcinoma of the bowel (3) Carcinoma of the lung.

Case One

At the age of 38, a woman was found to have Hodgkins Disease. Five years prior, she had had a hysterectomy. In 1939, she was treated with x-ray therapy for the Hodgkins Disease with complete clearing. In 1940, there was a recurrence. Biopsy again revealed Hodgkins Disease. She developed a depressive reaction and was treated with improvement until her husband had an emotional breakdown. She was then reassured by her physician that she would do well with both her medical problems.

In 1951, x-rays were reported as negative, but she was given x-ray therapy anyway. At this time she received 12 electric shock treatments for her depression. In 1955, she had fever, anemia, and weight loss. On x-ray a suspicious lesion was found in the bowel, which subsided with x-ray therapy.

I first saw her in September, 1957, at which time she weighed 136 pounds and had normal blood pressure. In the right supraclavicular area, there was an inch and a half scar.

I continued to treat her for her depressive state. She did fairly well with periods of no medication, stating that she had good and bad days. In July 1958, she was worried about becoming ill again. She began to have gastrointestinal upsets, but gained 13 pounds. Soon thereafter, I saw her in coma following an intentional overdose of barbiturates. Despite vigorous therapy, she died.

Autopsy showed no evidence of Hodgkins Disease.

Case Two

At the age of 56, a man developed rectal bleeding. During the following year, he lost 50 pounds and had recurrence of his rectal bleeding. X-rays revealed a tumor of the sigmoid. At surgery adenocarcinoma, grade three, with peritoneal metastasis was found. All visible metastasic lesions were removed. Surgery was done in three stages with a colostomy and then an end-to-end anastomosis, so that he was restored to normal bowel function.

Following surgery, he developed Parkinsons Disease.

At the age of 68, he reported severe burning pain at the site of his original external colostomy. After one week, a fistula developed. He drained fecal material. The area became very tender and irritated. He was treated symptomatically with an aluminum magnesium hydroxide proprietary. He had relief from the burning. X-rays then showed extensive diverticulosis and diverticulitis.

The following year, he had an extensive second degree burn of over half his body due to hot water. From this, he recovered completely.

At the age of 72, he died of coronary thrombosis, fifteen years after his original surgery.

Case Three

A retired banker was found to have active pulmonary tuberculosis with cavitation involving both upper lobes. He had a resection of the right upper lobe with residual disease remaining. He received drug therapy with conversion of sputum. At serial x-rays, he was found to have a new lesion in his left lung, which enlarged slowly. Bronchoscopy with biopsy revealed adenocarcinoma of the lung. Cobalt therapy was given.

He felt well for a year and a half, when he suddenly developed paralysis of the right side of the body and died in two days. Spinal fluid was negative.

Autopsy disclosed pulmonary fibrosis with no evidence of residual tumor or tuberculosis. The heart was normal.

Summary

1. Three patients are reported with "hopeless malignant conditions."

2. A woman lived 19 years after a diagnosis of Hodgkins Disease with recurrences which responded to x-ray. She died due to an overdose of barbiturates.

3. A man died 15 years after surgery for adenocarcinoma of the bowel with peritoneal metastasis. He also had Parkinsons Disease and far advanced diverticulosis. The cause of death was coronary thrombosis.

4. An adult male with a history of active pulmonary tuberculosis with resection and drug therapy developed a carcinoma of the left lung. This responded to cobalt therapy.
We must not give up hope.

292 River Road

Disclosure of Malpractice Committee Minutes

The following item is submitted by our counsel, Robert M. Backes, Esquire:

A recent California case* (not necessarily controlling in New Jersey) indicates that an attorney cannot be compelled to disclose activities of a Medical Society's Malpractice-Screening Committee.

An insurance carrier's attorney provided to defend a covered doctor Society member in a malpractice case was advised by a Committee of the Society, after review of the facts in the case and questioning.

By pretrial interrogatories directed to the attorney, the patient sought to learn the substance of the Committee's decision. The attorney's refusal on the basis of the attorney-client privilege was upheld, the Court indicating that the "work product" of an attorney is not discoverable unless the Court determines that the denial of such discovery will unfairly prejudice the party in preparing his case or will result in injustice. It was indicated that the patient could secure similar knowledge by taking depositions of the doctor and Committee members.

The Court implied that the Committee Plan established to assist in the settlement of malpractice cases is a worthy one which would not be aided if those present must disclose all that happened at a meeting. Such a disclosure requirement, the Court predicted, would eliminate such meetings.

Brown vs. *Superior Ct. of California,* 32 Cal. Rptr. 527 (Cal., July 19, 1963)

Here the Seton Hall group review the when, where, and how of ophthalmic surgery for esodeviations.

Surgery of Esodeviations*

Alfonse A. Cinotti, M.D./Jersey City
Paul T. McAlpine, M.D./Summit

The prime purpose of surgery of esodeviation is to align the visual axis and thus supplement medical treatment in the hope of securing a functional result (i.e. single biocular vision). Cosmetic improvements occur in a large proportion of cases, but functional results unfortunately have not been achieved to any great degree. It is hoped that early medical and surgical treatment will improve the functional success ratio.

Medical treatment consists of cyclopegic correction with glasses plus treatment of amblyopia by occlusion or atropinization. This should be instituted as soon as the diagnosis of strabismus is made. Unfortunately too many patients are allowed to go months or years before being brought to an ophthalmologist. The possibility of a good functional result decreases the longer the delay. Indeed, the trend now is toward early surgery of esodeviation in the hope of producing visual alignment before the development of abnormal visuosensory habits which usually deepen with time. Esodeviations which are present at birth are called congenital squints. These patients usually have large angles with little chance of improvement by medical means. Therefore several surgeons[1] have recommended surgery at 6 months of age[2]. Parks,[3] for example, suggests a bimedial recession of 5 millimeters if the esotropia is over 40 prism diopters at 6 millimeters. If within six weeks this is still a residual squint, a resection of the lateral recti is performed. Acquired strabismus (which may come on in the first or second year of life and begin as an intermittant strabismus) can also be treated by this type of surgery. Proponents of early surgery in these cases suggest that some fusion existed prior to the development of squint and therefore surgery within three to six months may improve the chances for a functional result. Following this procedure over a long period of time should aid in establishing whether early surgery is more effective in producing functional results than waiting until further development of the ocular muscles.

It is not wise to assume that *all* cases should be subjected to early surgery. It is better to decide this after a thorough evaluation of each patient. Patients with significant refractive errors should be given adequate trial with lenses. In this way, accommodative squints can be separated from the non or partially accommodators. Never operate on that portion of the squint which can be corrected by lenses.

Monocular squints should be treated by occlusion and/or cycloplegics in an effort to develop true alternation. There is no need for early surgery in these cases, since patients who fixate with only one eye are usually amblyopic and functional results are seldom possible. Alternate occlusion is also indicated on cross fixators in an attempt to improve abduction which must be stimulated. Those which develop good abduction after this treatment will require different surgery than the true cross fixators. One useful preoperative treatment is the alternate use of red filters. This aids in the development of macular fixation and the breaking up of abnormal correspondence.

In patients who can be studied with the major amblyoscope and who show fusional potential, including the cases of high phoria or phoriatropia, surgery can be done with impunity and

*This work comes from the Division of Ophthalmology, Seton Hall College of Medicine in Jersey City. The paper was read, by invitation, May 20, 1964 at the Annual Meeting of The Medical Society of New Jersey in Atlantic City.

with expectation of securing a good functional result.

Choice of the muscles to be operated on is not always simple. After meticulous consideration of all factors and after decision to operate has been made, the next question is which muscle or muscles to treat. A study of the esodeviation for near and far may give valuable information. If the ET† is greater for distance than near, there is a divergence insufficiency; while if greater for near than far, it is a convergence excess. Patients with equal deviation for near and far are a combination of divergence insufficiency and convergence excess.

With convergence excess, the near point of convergence will be good and recession of one or more medial recti would be indicated, depending on the size of the deviation. If the deviation is over 50 prism diopters, a full bimedial recession might not prove adequate. If there is a divergence insufficiency and the angle of squint is small, resection of the lateral recti would be indicated. If the angle of deviation is large, a recession-resection operation would be more effective. These latter cases usually have a relatively poor near-point of convergence, and recession of the medial recti would further weaken this movement. Where the deviation is equal for far and near, surgery may be divided between the medial and lateral recti. In esotropia which is comitant and the eyes can alternate fixation, symetrical surgery should be done. This commitance will be maintained in most cases. Naturally when the angle of squint is excessive, it is not possible to do symetrical surgery if one desires a cosmetic result.

Cross fixators may offer a problem. These patients should be tried on alternate occlusion to stimulate abduction. If the angle of deviation is small, a resection of the lateral recti might prove effective. It is always wise at the time of surgery to do a forced duction test on the medial recti to determine if fascial adhesions are causing the weakness of abduction.

If the deviation is large, a recession-resection operation will usually give best results. If there is a good near point of convergence, a bimedial recession can be done.

True monocular squinters usually have amblyopia. Symetrical surgery will be of little use, since the possibility of a functional result is minimal. Recession and resection of the amblyopic eye will usually give best cosmetic results.

The true accommodative squinter who has very little esodeviation for distance should be treated medically, if possible. When doing surgery, a small bimedial recession or a recession of one muscle can be done. However, the possibility of developing a divergence for distance should be remembered. The partial accommodative squinter should be operated on only for the residual deviation after the use of maximum correction.

The presence of vertical deviations and A. and V.‡ phenomena should next be considered. This is a controversial subject, there being those who do not believe in doing vertical surgery and those who believe the hypertropia should be corrected first or along with the horizontal deviation. There is no doubt that vertical deviation of more than 10 prism diopters and horizontal deviation of 20 prism diopters will remain after the other is corrected.[4] Safest surgical approach is to operate in stages: correct the greatest deviation first; or correct some of each if they are equal. Thus if the vertical deviation is small, the horizontal may be treated first. If the vertical is larger, then it is treated first. If they are both appreciable, a combination of surgery should be done.

A. and V.‡ phenomena will be found in 10 per cent of the esodeviations. If the deviation is less than 15 prism diopters (that is, the difference in the eyes up or the eyes down position), it need not be corrected. If it is greater than this, then the following rules should be adhered to:

In V.‡ phenomenon, the insertions are lowered with recession of the medial recti and

†Short for esotropia or convergent strabismus.

‡Refers to a condition where measurements are different when eyes look up from down. When the E.T. (convergent strabismus) is greater in the up position than in the down position, an "A" phenomenon exists. When the E.T. is greater in eyes down than in eyes up, a "V" phenomenon is present.

raised with resection of the lateral recti. In A.‡ phenomenon, the insertions are raised on medial rectus recession and lowered in lateral rectus resection. In V. esodeviation which are commitant, bimedial recessions will generally aid significantly in reducing this phenomenon. By droping the insertions, there will also be an increase in the correction of the esodeviation. Recession or tenotomy of inferior oblique may be done, but they can be expected to take care of only 20 prism diopters. Jampolsky[5] favors weakening procedures for A.‡ phenomenon on the superior obliques and on the inferior obliques in V.‡ Phenomenon.

The A. esodeviations often preclude the usual bimedial recession, for this syndrome will often be aggravated by this procedure.

There are certain general principles of muscle surgery that should be remembered.

(1) For each millimeter of recession, one expects to correct 4 to 5 diopters of deviation, while for each millimeter of resection a correction of 3 to 4 diopters can bc expected.

(2) Never recess a medial rectus more than 4½ millimeters or resect a lateral rectus more than 10 millimeters to prevent a limitation of adduction.

(3) Recession resection operations on one eye will produce a greater amount of correction when done at the same time than when done in two stages.

(4) The same operation will produce a greater effect on infants than in adults, because the infant's eyeballs are smaller.

(5) Never operate on more than two recti muscles at one time in order to prevent damage to the eye.

The two commonest problems in muscle surgery are under-corrections and over-corrections. In under-corrections, attempts should be made to operate on muscles not previously treated because of the possibility of the occurrence of fibrosis of muscles and adhesions to surrounding tissues.

Over-correction usually requires more surgery to correct the secondary exotropia than would usually be done if the exotropia were the primary deviation.

One surgical technic is to open the conjunctiva directly over the muscle and cut adhesions without dropping the conjunctiva. Once the adhesions are incised, Tenon's capsule is grasped above the superior border of the muscle and opened. A muscle hook is then inserted under the muscle which can then be cleared of Tenon's capsule by sharp dissection. A 0000 plain catgut suture with a small sharp needle is used to resuture the muscle to the globe. Tie all sutures on the *outside* of the conjunctiva. If this is done, postoperative reaction is less, and there will never be unabsorbed buried knots to be removed at a later date.

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3285 Hudson Blvd. (Dr. Cinotti)

Recurrent Thrombocytopenic Purpura

Recurrent episodes of acute idiopathic thrombocytopenic purpura (ITP) were observed in four patients who were otherwise healthy. In one patient, the episodes of acute ITP occurred without apparent antecedent illness or drug exposure. In the other patients there appeared to be a relationship to allergy, vaccine exposure, or presumed viral exposure. Platelet survival studies demonstrated that development of thrombocytopenia was associated with the appearance of a potent thrombocytolytic process which disappeared completely during remissions. These cases are distinguished from those of chronic ITP by the prolonged and complete remissions of the bleeding manifestations and by the completely normal platelet counts and normal platelet survival between the thrombocytopenic episodes. Recurrent acute idiopathic thrombocytopenic purpura appears to represent another variant of the heterogeneous ITP syndrome.

W. Dameshek, S. Ebbe, L. Greenberg, and M. Baldini

New Eng J Med 269:647 (Sept 26) 1963

Here the authors show how cardiac catheterization and related technics can provide guide lines in the management of mitral stenosis.

Mitral Stenosis: Catheterize or Not?*

Edwin L. Rothfeld, M.D. et al/Newark

Selection of patients with rheumatic mitral stenosis for mitral commissurotomy is based on clinical evaluation and an appreciation of the natural history of the disease. In addition, cardiac catheterization contributes essential information in predicting which patients will benefit from surgery. We have reviewed our data to demonstrate how catheterization aids in the management of these patients.

Material and Methods

During the past five years, 61 patients with pure or predominant rheumatic mitral stenosis had catheterizations of the left and right heart and selective angiocardiography performed at the Newark Beth Israel Hospital. These patients are divided into four groups based on pathophysiologic findings: (I) predominant mechanical mitral block; (II) mitral block with moderate to severe pulmonary vascular disease; (III) predominant myocardial failure; and (IV) no hemodynamic abnormality before or after exercise. This classification is similar to that of Harvey and Ferrer[1]. There were 34 patients in group I; 16 in group II; 8 in group III; and 3 in group IV.

The usual right heart catheterization methods were used. With the Seldinger technic, an arterial catheter was passed retrograde from the brachial or femoral artery into the left ventricle. The mitral diastolic filling gradient was calculated by subtracting the left ventricular from the pulmonary artery wedge pressure in diastole. The cardiac output was determined by the direct Fick method. The pulmonary artery pressure, the right ventricular end-diastolic pressure, and the cardiac output were measured before and after three minutes of supine leg exercises. Angiocardiography, employing either cut film or ciné recording, was performed with the patient positioned for the lateral projection. The arterial catheter was placed with its tip in the inferior third of the left ventricle. High pressure injection was used, and the usual volume of contrast medium was 0.5 cubic centimeters per pound of body weight. This type of study provided a good demonstration of the presence of mitral regurgitation.

Report of Cases

One case from each group is described in order to illustrate the clinical and physiologic findings.

Group I: A 49 year old woman had a history of rheumatic fever at age 12, followed by minimal dyspnea on exertion. At age 38, she was digitalized because of increasing dyspnea, orthopnea, paroxysmal nocturnal dyspnea, and ankle edema with a satisfactory response. In the 6 months prior to evaluation she became aware of increasing dyspnea, despite careful medical management. Physical examination revealed normal sinus rhythm and the typical auscultatory findings of pure mitral stenosis. The lung fields were clear, and there was no edema. An electrocardiogram showed sinus rhythm, left atrial and right ventricular enlargement; chest X-ray demonstrated left atrial and right ventricular hypertrophy, pulmonary vascular engorgement, and Kerley B lines. There were no intracardiac calcifications. Cardiac catheterization showed a mean mitral diastolic filling gradient of 18 millimeters of mercury.

*This work is from the Hemodynamics Department of the Newark Beth Israel Hospital. In addition to Dr. Rothfeld, co-authors are Doctors I. R. Zucker, Asa H. Crews, C. Z. Berman, Lawrence Gilbert, and Arthur Bernstein.

[1]Harvey, R. M. and Ferrer, M.I. *Circulation.* 20:442 (1959.)

At rest, the pulmonary artery pressure was 45/12 millimeters of mercury, and the cardiac output was 2.75 L./min. After exercise the pulmonary artery pressure rose to 65/30 millimeters of mercury, and the cardiac output was 2.90 L./min. Right ventricular end-diastolic pressure was less than 5 millimeters of mercury, both before and after exercise. Left ventricular angiography demonstrated no mitral regurgitation. After mitral commissurotomy, there was a remarkable subjective improvement. In the 18 months following surgery, there has been a considerable increase in exercise tolerance. The auscultatory findings remain unchanged.

This patient's functional deficit was due to relatively pure mechanical mitral block. The cardiac output was low, and there was moderate pulmonary hypertension accentuated on exercise. Normal right ventricular end-diastolic pressure indicated adequate myocardial function. These patients usually have dyspnea of fairly recent onset and relatively small hearts. As might be expected, nearly all do well with surgery.

Group II: A 36 year old man first sought medical aid at age 32 for dyspnea, weakness, and marked ankle edema. Physical examination showed marked edema of the lower extremities, tender hepatomegaly, and rales at both lung bases. There was atrial fibrillation, and a loud rumbling diastolic murmur at the apex that began after an opening snap. A soft holosystolic blowing murmur that became louder with inspiration was heard best over the xyphoid. An electrocardiogram showed atrial fibrillation and right ventricular hypertrophy. X-ray revealed central pulmonary vascular engorgement, enlargement of the left atrium and right ventricle, and some dilatation of the right atrium. Mitral valvular and left atrial calcification were reported. At cardiac catheterization, the mean mitral diastolic filling gradient was 25 millimeters of mercury. The pulmonary artery pressure was 75/30 millimeters of mercury, and the cardiac output 3.40 L./min. at rest. After exercise the pulmonary artery pressure was 100/50 millimeters of mercury, and the cardiac output, 3.65 L./min. The right ventricular end-diastolic pressure was not abnormal. Injection of radio-opaque dye into the right ventricle showed a moderate degree of tricuspid regurgitation. Injection of dye into the left ventricle demonstrated no left atrial filling. This patient was recommended for mitral commissurotomy.

Hemodynamic evaluation in this patient demonstrated mitral block and marked pulmonary hypertension. After digitalization, there was no evidence of myocardial failure. The tricuspid insufficiency was probably secondary to pulmonary hypertension. In addition to mitral block, patients in this group have pulmonary vascular disease as we have noted on lung biopsy. It is our opinion that patients in this group benefit from mitral commissurotomy, although the results are not nearly as satisfactory as in those patients with pure mechanical mitral block.

Group III: A 43 year old woman had been treated for episodes of congestive failure due to rheumatic heart disease for at least 10 years preceding surgery. Physical examination disclosed fine bibasilar rales, atrial fibrillation, cardiomegaly, and auscultatory evidence of mitral stenosis. An electrocardiogram revealed atrial fibrillation and right ventricular hypertrophy. X-ray showed marked right ventricular and left atrial enlargement, pulmonary vascular engorgement, and probable parenchymal fibrosis. Mitral valvular calcifications were also described. At cardiac catheterization, the mean mitral diastolic filling gradient was 30 millimeters of mercury. At rest, the pulmonary artery pressure was 75/35 millimeters of mercury and the cardiac output was 2.20 L./min. After exercise, the pulmonary artery pressure was 65/35 millimeters of mercury, and the cardiac output 2.10 L./min. The right ventricular end-diastolic pressure was 18 millimeters of mercury, at rest and 30 millimeters of mercury after exercise. She died 48 hours after a mitral commissurotomy in hypodynamic failure. Postmortem examination disclosed residual mitral and submitral stenosis, with fusion, thickening, and shortening of the chordae tendinae. All cardiac chambers were markedly dilated and hypertrophied. There was extensive fibrosis of the lungs and moderate pulmonary arteriosclerosis.

In this patient the main hemodynamic finding was myocardial failure. The cardiac output was low both at rest and after exercise, and the right ventricular end-diastolic pressure was markedly elevated. Mitral commissurotomy does little for these patients because their problem is myocardial failure rather than mechanical mitral block. In our experience, surgical results in this group have been uniformly poor.

Group IV: A 38 year old woman was referred for evaluation of mitral stenosis. The murmur was first detected at age 20 on a routine physical examination. Since that time, she had multiple functional complaints including dizziness, sighing respirations, and hyperventilation tetany. There was no real dyspnea, orthopnea, cough, fatigue, or edema. Physical examination showed sinus rhythm and the typical murmur of mitral stenosis. An electrocardiogram was normal, and x-ray of the chest revealed only questionable left atrial enlargement. Cardiac catheterization showed a mean mitral diastolic filling gradient of 7 millimeters of mercury. The pulmonary artery pressure was 23/10 millimeters of mercury, at rest and 30/15 millimeters of mercury, after exercise. Cardiac output was 4.15 L./min at rest and 8.10 L./min. after exercise. The right ventricular end-diastolic pressure was less than 5 millimeters of mercury before and after exercise.

This patient has the typical auscultatory findings of mitral stenosis, but the cardiodynamic evaluation is normal. Only periodic observation is necessary at this time.

Discussion

Combined cardiac catheterization and angiocardiography provide a rational basis for the evaluation and management of the patient

with mitral stenosis. Calculation of the diastolic filling gradient across the mitral valve offers an objective index of the severity of the stenosis and a baseline for comparison with post-operative studies. An estimate of associated mitral regurgitation may be gained from angiocardiography employing selective injection of radiopaque dye into the left ventricle. Catheterization technics are also of value in detecting aortic and tricuspid valvular lesions that may complicate the picture in mitral stenosis. We have been impressed with the frequency of dynamically significant mitral regurgitation, aortic and tricuspid lesions in patients in whom only mitral stenosis was suspected clinically.

In the patient with pure or predominant mitral stenosis, measurement of cardiac output, pulmonary artery pressure, and right ventricular end-diastolic pressure before and after exercise serves to describe the main functional deficit and helps to predict the surgical results.

Group I: Mechanical Mitral Block. When mechanical block is the main problem, the cardiac output is low at rest and does not increase normally with exercise. The pulmonary artery pressure is minimally or moderately elevated at rest with a further increase after exercise. The right ventricular end-diastolic pressure is normal indicating adequate myocardial function. Clinically, these patients usually have a history of progressive dyspnea of fairly recent onset. Their hearts are only minimally or moderately enlarged, and congestive failure is fairly well controlled by medical means. Patients in this group are ideal candidates for mitral commissurotomy. In general, they show considerable subjective and objective improvement postoperatively.

Group II: Pulmonary Vascular Disease. These patients have mitral block plus pulmonary arteriosclerosis. Physiologically, they are characterized by marked pulmonary hypertension at rest which approaches systemic levels on exercise. It is frequently difficult to differentiate this group from the preceding on clinical grounds alone. At present, we feel that surgery will benefit these patients since it relieves the block at the level of the valve which contributes at least partially to the pulmonary hypertension.

Group III: Myocardial Failure. Patients in this group have low cardiac outputs and an elevated end-diastolic pressure in the ventricle. The pulmonary artery pressure may be normal or only slightly elevated. These patients have large hearts, atrial fibrillation, intracardiac calcification, and chronic congestive failure. Surgical results in this group are uniformly poor, and they are probably best managed by medical means. We have seen several cases of severe mechanical block without myocardial failure in which the clinical findings mimicked those in this group. In these situations, catheterization is necessary to determine the physiologic fault.

Group IV: Normal Cardiodynamics. We have studied 3 patients with auscultatory mitral stenosis who had normal dynamic findings both before and after exercise. We advise only periodic observation in these cases. If a patient with auscultatory mitral stenosis is a poor historian, a true evaluation of the clinical picture may be possible only with cardiac catheterization.

Summary

1. Cardiac catheterization and allied technics are of importance in the management of patients with rheumatic mitral stenosis

2. Based on physiologic findings provided by catheterization, these patients can be divided into 4 groups: predominant mitral block; mitral block with pulmonary vascular disease; predominant myocardial failure; and no hemodynamic abnormality.

3. The first two groups usually benefit from mitral commissurotomy, while the latter two are best managed by medical means and periodic observation.

201 Lyons Avenue

Economical Plastic Museum Jars

A simple fabrication method for jars is outlined in 8 steps. The jars are easily fabricated in the laboratory with a minimum of equipment, and are suitable for rapid, economical, commercial fabrication. By fabricating the front and sides of the jars in one piece, error in construction is reduced and strength is increased. They may be fabricated for each specimen or in standard sies. The process of mounting and sealing specimens is simplified and fluid may be changed without opening the jar. Mounts are artistically superior to glass mounts. The jars are practical for small or large museums as maintenance is greatly reduced.

P. R. Joram

Amer J Clin Path 40:405 (Oct) 1963

Are hay fever and asthma serious enough to justify repository therapy? Dr. Seidmon thinks not.

Complications of Repository Therapy*

Edward E. Seidmon, M.D./Plainfield

Risks in treating hay fever are justified to a degree by the severity of the disease. Hay fever carries no mortality, and known accepted methods of aqueous therapy are painless and reasonable. On the other hand, repository emulsion therapy is only in the experimental stages and has not as yet been accepted by the F.D.A. as a standard method. Further, every allergist using emulsion therapy sooner or later sees complications in his patients. Such complications are as follows:

1. Fever.
2. Constitutional reactions.
3. Muscle soreness of several days to a week in duration.
4. Cysts or nodules of the muscles.
5. Draining cold abscesses.
6. Draining infected abscesses.
7. Lymphohematogenous dissemination of the adjuvant.
8. High response of local site reactions (93 per cent).
9. Oil granuloma (tuberculin type reaction of subcutaneous tissue).
10. Oil tuberculoid granuloma of subcutaneous tissue.
11. Oil granuloma of fibrosis and oil cysts.
12. Vacuoles of oil in subcutaneous oil granuloma.
13. Subcutaneous oil granuloma with necrosis.
14. Regional lymph nodes with vacuoles of oil with macrophage response.
15. Foreign body type granulomata.

Criep[1] has done rabbit studies which reveal the following:

1. A third of normal rabbits injected with Drakeol®-Arlacel® showed inflammatory reactions in the brains and kidneys. The kidney lesion is usually an interstitional focal nephritis. There is also some papillitis and some vasculitis. In the brain, the rabbits showed small foci of recrosis and lympathic infiltration.

2. Within 2 to 23 days, skin areas injected with emulsion showed dilated lymphatics and histiocytes in the upper dermis, lipid granulomata, and neutrophilic infiltration. There is some perivascular round cell infiltration. In the deep dermis there are dilated lymphatics and foci of necrosis with abscess formation.

3. Lungs showed most significant changes consisting of granulomatous reactions with aggregates of histiocytes and plasma cells. Interstitial and perivascular lymphocytic infiltrate was present. There was also mild focal vasculitis. Macrophages were seen in the wall of the blood vessel. Also noted was peribronchial foam cell infiltrate and eosinophile infiltrate under the endothelium and around the wall of the vessel.

4. In the liver, they reported round cell infiltration in the portal triad and mild vasculitis. They found large granulomata in the portal areas comprised of lymphocytes and macrophage cells.

5. One rabbit demonstrated pancreatitis accompanied by granulomatous formations. The lesion was comprised of lymphocytes, plasma, and macrophage cells. In another animal, in the spleen there was a lesion of granulomatous reaction accompanied by minute pale areas and central epithelioid cells.

Laufer[2] and Steiner[3] injected rabbits with Freund's adjuvant. These animals developed disseminated systemic granulomata throughout the entire body including the lymph nodes, lung, liver, kidney, skeletal muscles, and heart.

*Read May 18, 1964 at the 198th Annual Meeting of The Medical Society of New Jersey in Atlantic City.

Freund's adjuvant stimulates the reticuloendothelial system in rabbits, and that is why so many lesions were found in lung tissue.

Summary

1. Emulsion and repository therapies can cause serious and pathologic tissue responses.
2. Hay fever, asthma, and related disorders are not serious enough to justify the risk of these complications.

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Physicians who wish to borrow these books may do so by requesting them from the Library by telephone (PIlgrim 8-3430) or by mail. If the book is out when the request is received, it will be made available upon its return.

Dr. deGara here compactly reviews the therapeutic weapons available for the treatment of asthma in children.

Treatment of Bronchial Asthma In Infancy and Childhood*

Paul F. deGara, M.D./New York City

Before discussing the therapeutic features of childhood asthma it may be of interest to examine the figures shown in Table 1. These figures speak for themselves and indicate the importance and magnitude of the problem.

In Table 2 the patients' age at the onset of asthma is shown, as reported by Broder *et al.*[2]

TABLE 1
ILLNESS AMONG CHILDREN
U. S. NATIONAL HEALTH SURVEY
JULY 1959 to JUNE 1961

Average Annual Number of Asthmatics ..	1,595,000
Restricted Activity Days*	24,163,000
Bedrest Days*	11,656,000
Days Lost from School*	7,534,000

*For children under the age of 16.

TABLE 2
AGE OF ONSET OF ASTHMA

AGE	PER CENT
0-4	31
5-9	17
10-14	10
Older	42
	100%

To advise proper therapy, a correct diagnosis obviously is essential. This requires a thorough history with special emphasis on environmental factors: meticulous physical examination; and certain, selected laboratory work, much of which can be done in the office of the general practitioner. The latter includes: a complete blood count with special reference to eosinophilia, radiographic examination of the chest, and allergy skin tests.

After obtaining the correct diagnosis, after appraising the factors involved, the following treatment modalities—singly or in combination —may be recommenced:

Specific therapies including various types of hyposensitization and, of course, avoidance.

Concomitant treatment falls into five categories: (a) antibiotics, (b) chemotherapy, (c) bacterial vaccines, (d) gamma globulin, and (e) psychotherapy.

Symptomatic treatment includes sedation, bronchiodilators, sympathomimetic preparations, and steroids.

Avoidance of avoidable offenders is the optimal approach. If a child is allergic to the feathers in his pillow, replacement with a non-allergic pillow is an easy and painless therapy and, possibly, cure. Here an accurate history is essential. If a child is allergic to a pet in his surroundings, elimination of the animal may be the cause of mental anguish and require special handling. Most foods to which a patient is allergic (clinically, not just by skin test) can be replaced. The most troublesome problem is true milk allergy in a small infant. Even the adequate substitutes are now available, such as goat's milk, soybean preparations, and amino-acid compounds. Sometime, food allergy of one child in a large family creates a special problem, because of the constant temptation requiring special consideration.

Hyposensitization therapy is confined to inhalants. It is given for offenders that cannot be avoided, such as pollens, molds, and house-dust. Conventional therapy with aqueous extracts has been in use for several decades, and its advantages and risks are known. A disadvantage of this form of therapy is the length

*Read at the 198th Annual Meeting of The Medical Society of New Jersey, Joint Session of Allergy and General Practice, Atlantic City, May 18, 1964.

of time required to produce hyposensitization and the need of frequent booster injections over a prolonged period of time. A new method[3] using alum-precipitated pyridine extracts[4] shows great promise[5] and partly overcomes the disadvantages of treatments with aqueous extracts. Finally, repository[6] treatment has a place.

Concomitant therapy includes treatment of infections that may act as a trigger even if not as a cause. If it recurs frequently, the use of bacterial vaccines, possibly, of autogenous preparations should be kept in mind. The opinions about the value of this for prophylaxis are divided. In my experience and that of others, good results are noted in a considerable number of children. However, I rarely prescribe vaccine therapy alone. If a child needs hyposensitization to other inhalants and if there is a history of frequent upper respiratory infections, ushering in asthmatic attacks, I add a bacterial vaccine to the treatment set. If cultures indicate the presence of unusual germs or combinations of germs, an autogenous vaccine should be added.

Gamma globulin has been recommended by some authors[7],[8],[9], but poor results were noted by others[10]. The importance of quantitative studies was emphasized by Goldfarb and Fudenberg[11]. Also, the question of dysgammaglobulinemia[12] must be kept in mind. Good results with small doses of gamma globulin were recently reported by Redner and Markow[9]. According to those authors ". . . these cannot be explained by any scientific, immunologic, or allergic reasoning at the present time." Gamma globulin in immunologically non-responsive asthmatic children was reported recently by Green and his co-workers[13].

Psychotherapy has a definite place. It may, indeed, become necessary to send a chronically asthmatic child to a Home[14].

For *symptomatic* therapy, bronchodilators, sympathomimetic drugs, and steroids are used. The spectacular results of epinephrine by injection, of aminophylline by the rectal route, of oral therapy with ephedrine, of nebulizers, of expectorants, of oxygen for cyanosis and anoxia, and of sedation (preferably with chloral hydarate) are too well known to require much discussion[15].

Aminophylline is not well tolerated by everybody. If on first administration, abdominal complaints are reported, then aminophylline should be discontinued immediately.[16] Nebulizers should be permitted sparingly, because they may be habit forming[17] and may cause other deleterious effects.

When should *steroids* be used? Not as first choice and not as last choice. They should be given when the other drugs mentioned above have been proved to be ineffective. Therapeutic doses should be prescribed for a few days and tapered off thereafter within 7 to 10 days. Short courses (7 to 10 days' duration) may be repeated, if necessary, and are preferable to continuous therapy or to haphazard treatment with steroid compounds. Among the side effects of steroid therapy, remember stunting of growth and the danger of an infection with chicken pox[18].

Antihistaminic preparations are of very limited use and possibly contraindicated in asthmatic conditions.

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133 East 58th Street

In about one fifth of the cases, 5-Fluorouracil will be helpful in relieving the more distressing symptoms of gastric cancer.

Chemotherapeutic Agents in the Management of Gastric Cancer*

Bernard J. Koven, M.D./Jersey City

Stomach cancer ranked as the third leading cause of cancer mortality in men in 1958 and as the fourth leading cause in women during the same year. Unfortunately, once clinical symptoms have appeared, the cure rates by best surgical methods now available are distressingly low. For these reasons, there still remain a large number of patients who have unresectable stomach cancer when first seen or who will develop recurrent disease following their initial surgical attempt at cure. Radiation therapy in stomach cancer has not been effective as a primary form of management. Furthermore, residual and recurrent gastric cancer is relatively insensitive to radiotherapy and the use of this modality is not recommended in these settings.

Chemotherapy

Shortly after World War II, the drug nitrogen mustard was first used in clinical cancer. After objective remissions were shown possible in Hodgkin's Disease and other malignant lymphomas, nitrogen mustard was tested in a variety of malignant diseases. There has been sufficient experience in the use of nitrogen mustard in stomach cancer to indicate that it is not a very useful form of management. More recently, newer derivatives of nitrogen mustard, members of the class of alkylating agents, have been tested in advanced stomach cancer. Results with these newer alkylating agents have not been much better than with the original drug nitrogen mustard. As other agents became available for trial in human cancer — for example, methotrexate and 6-mercaptopurine — trials were undertaken in gastric cancer but again with unimpressive results.

In 1954, Rutman[1] and his colleagues observed that liver tumors in rats had an increased utilization of uracil, compared to normal rat liver. For this reason, Heidelberger[2] developed the drug 5-fluorouracil and related antagonists of the pyrimidine bases. First clinical studies of fluorouracil in patients were reported by McIver[3] and Curreri *et al.*[4] They found definite objective tumor regression in patients with gastrointestinal cancer, including tumors of the colon and stomach. Subsequent studies by these workers and by investigators[5–8] at other centers in the United States have shown wide variation in response rates depending upon the criteria of response used and upon the stage of illness.



5-Fluorouracil

*This work comes from the Seton Hall College of Medicine and Surgery. It was read May 19, 1964 at the Annual Meeting of The Medical Society of New Jersey.

The evaluation of objective response in gastric cancer (and gastro-intestinal cancer in general) is difficult because of the anatomic sites involved by these tumors. Objective measurements of changes in tumor size are often impossible to obtain as pointed out by Zubrod[9]. However, in a number of papers [3] to [9], reported figures for objective remissions has been approximately 20 per cent.

A number of fluorinated pyrimidine drugs in addition to 5-fluorouracil were synthesized with the hope that one or more would offer a greater therapeutic potential. However extensive testing by a number of investigators has not supported this hope.

The drug 5-fluorouracil is now available for clinical use in patients with unresectable or recurrent cancer. It is *not* now recommended as adjuvant therapy at the time of initial surgery in resectable cases of stomach cancer or other forms of operable cancer.

Case Selection

Neither 5-fluorouracil nor any other chemotherapy agent currently available is, in any sense, curative for inoperable or recurrent stomach cancer. I feel, therefore, that the drug should be reserved for the time when the patient develops dangerous or distressing symptoms, such as severe pain or obstruction of the gastrointestinal tract or troublesome metastatic liver disease. In general, it has been found that the toxic effects of this agent are most severe in patients with a poor nutritional state or in those whose bone marrow function has been previously depressed by other therapy. In the brochure supplied by the manufacturer, it is stated that the drug should not be used in patients who have undergone recent major surgery or those with a history of high-dose pelvic radiation, previous use of alkylating agents, or who have widespread involvement of bone marrow by metastatic disease or extensive liver impairment or jaundice.

Dosage

During the past 6 or 7 years, 5-fluorouracil has been given to patients under clinical investigation by a variety of dosage schedules. While there still may be further modification, the following plan of therapy currently is recommended: 15 milligrams per kilogram are injected directly intravenously once daily for 4 successive days. If no toxicity is observed, 7.5 milligrams per kilogram are given on the 6th, 8th, 10th, and 12th days unless toxicity occurs before then. No therapy is given on the 5th, 7th, 9th, or 11th days. This sequence of injections constitutes an initial course of therapy. The initial course should always be given in the hospital, in order to observe evidence of bone marrow toxicity or other significant drug effects. Some investigators repeat this course of therapy after one month if all signs of toxicity have disappeared. Other workers[8] place patients on weekly or bi-weekly maintenance injections of 7.5 to 10 milligrams per kilogram and keep the patient near toxic levels in order to maintain a remission as long as possible when benefit is produced by the initial course of therapy.

Side-Effects

In addition to depression of bone marrow function (with leucopenia and thrombocytopenia as major manifestations), other signs and symptoms may appear. These include nausea and anorexia, which are almost always noted. Vomiting is occasional. Diarrhea is frequently noted and may progress to severe uncontrollable bloody diarrhea if the drug is not stopped soon after its appearance. Stomatitis, alopecia, and dermatitis may also be produced. Because of the potential severity of these manifestations of toxicity, it is recommended that a drug trial with 5-fluorouracil be terminated whenever any of the following evidences of toxicity appear: (1) white blood count less than 3,500; (2) platelet count under 100,000; (3) ulceration of the mouth or lips; (4) diarrhea of any severity or gastrointestinal ulceration; (5) hemorrhage from any site.

An accurate daily blood count and careful clinical evaluation of patients under treatment with 5-fluorouracil are essential if it is to be used with reasonable safety. Following completion of a course of therapy, the patient should be meticulously observed for several additional

weeks, since signs of toxicity may appear after the completion of an initial course of the drug. Measurements of all accessible areas of tumors should be made and carefully recorded prior to the onset of therapy, so that these measurements in addition to relevant x-rays and blood chemical determinations may be used in assessing benefit or lack of benefit to the patient. There may be times, however, when it is difficult to demonstrate objective improvement in the stomach cancer patient, and his response will be measured in subjective terms such as his general feeling of well-being, the ability to eat larger meals, and his over-all performance status. If convincing evidence of improvement is produced by the initial drug trial, maintenance therapy on a weekly or bi-weekly basis may be given, provided signs of toxicity have disappeared.

The Future of Chemotherapy

With the availability of 5-fluorouracil as an effective drug in some cases of stomach cancer, further modification of dosage and combination of 5-fluorouracil with other chemotherapy agents are undergoing study. At the present time, our group at the Jersey City Medical Center[10] is evaluating the combined use of the drugs 5-fluorouracil and thio-TEPA in a variety of solid tumors including stomach cancer. We will report the results of our studies elsewhere. Currently, we have the impression that this combination, in a modified dosage schedule, is at least as effective as 5-fluorouracil alone in solid tumors with considerably less clinical toxicity. Other drugs are becoming available for clinical evaluation, and these used alone or in combination with the presently available agents may offer greater palliation and prolonged survival for the unfortunate stomach cancer patient who represents a major problem today.

Summary

Carcinoma of the stomach is largely refractory to treatment with chemotherapy utilizing alkylating agents, such as nitrogen mustard and its newer analogs. However, some objective benefit may be produced with the drug 5-fluorouracil in about 20 per cent of selected cases. Since toxicity may be severe, the physician must be familiar with the clinical and laboratory abnormalities which this agent may produce in order to avoid irreversible toxic effects. Further modification of dosage schedules may improve the therapeutic index for this agent.

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24 Baldwin Avenue

Experimental Aspects of Tobacco Carcinogenesis

Experimental studies demonstrated that tobacco smoke condensate is carcinogenic to a variety of animal tissues. Chemical constituents were determined which at least in part may can be reduced in the smoke. Laboratory experiaccount for the tumorigenic activity. It can also be shown that some of these constituents mentation with animals is being carried out in an attempt to uncover the possible mechanism involved.

E. L. Wynder and D. Hoffman
Dis Chest 44:337 (Oct) 1963

Here is a patient whose small bowel was reduced from 23 to 3½ feet . . . yet who maintained adequate nutritional levels.

Nutrition Maintenance In An Enterectomized Patient

Apolinar de la Cruz, M.D.*/Paramus
Hamza Unal, M.D.*/Paramus
Abraham I. Friedman, M.D./Hackensack

The small intestine is of critical importance in the processes of digestion, metabolism, and absorption. This raises one significant query: how much of the small intestine may be removed without serious hazard to the patient's metabolism and nutritional state?

Not until 1935 was there any comprehensive review of this. In that year, Haymond[1] analyzed 257 cases of massive resection. By our own definition, "massive" refers to a loss of more than 50 per cent of the length of the small intestine. Haymond called a resection "extensive" if more than 200 centimeters of gut were removed. Haymond's conclusion was that 50 per cent of the small bowel may be removed without suffering significant deficiencies. Indeed, a summary of the results of experimental resections in animals[2] and extensive removal of the small intestine in man[3] leads to the conclusion that approximately two-thirds of the small intestine can be excised without serious risk to life[4]. When 80 per cent or more of the small bowel was removed, the results were often fatal, although there have been notable exceptions[5,6,7,8]. The important consideration is not the length of small intestine removed, but rather the length that remains to carry on vital functions.

The present case is unusual because the patient suffered a massive resection of the small intestine following a previous subtotal gastrectomy for a duodenal ulcer.

Case Report

A 58-year old man was admitted to Bergen Pines County Hospital in 1959 complaining of progressive weight loss and general body weakness of eight months' duration. He had been operated on for a perforated duodenal ulcer in 1945 with simple closure. Subtotal gastrectomy had been done in 1951. In April 1958, at another hospital, a massive small bowel resection was performed because of gangrene due to volvulus. The operative report declared that the surgeon removed 21 feet (610 centimeters) of small bowel. The total length of the small intestine that remained from the gastrojejunostomy to the cecal junction was reported as only 14 inches. Following surgery, he passed fifteen to twenty stools a day and lost 22 pounds in five months. The diarrhea subsided moderately at the time of admission. There was no recent history of tetany, bleeding tendency, or skin changes.

Physical examination on admission showed a poorly nourished, poorly developed, white male in no acute distress with 2 plus pittable edema of the face and extremities. His weight was 92 pounds. Blood pressure was 120/60. Tongue was dry and coated. There were several scars on the abdomen, which was moderately distended.

Laboratory findings included hemoglobin 11.1 grams per cent; white blood count 5,250 differential was normal; a negative urinalysis, fat 2 plus and occult blood 1 plus in several random stools. Blood chemistries showed a non-protein nitrogen of 34; total protein 6; albumin 3; globulin 3; sodium 143; chlorides 102; potassium 4.7 mEq/L; alkaline phosphatase 2.2 B.U. Serum calcium and serum phosphorus were done three times with values ranging from 8.5 to 11.1 for the former and 3.8 to 4.8 for phosphorus. An intravenous glucose tolerance test was reported as follows: fasting 81, 129, 133, and 97% at fifteen minute intervals; oral glucose tolerance test—fasting 80, 133, 133, 102, and 96 mg.% at hourly intervals.

Barium meal examination revealed a two-thirds subtotal gastrectomy (Billroth II) and resection of all but 3½ feet of small intestine estimated radiologically (Fig. I).

He was placed on small frequent feedings, high in

*Resident Physicians, Bergen Pines Hospital, Paramus, N. J. Dr. Friedman is chief of gastro-enterology at that hospital.

vitamins, proteins, and carbohydrates but low in fats. We gave him 6 tablets a day of a proprietary pancreas preparation.† He recovered strength. The edema disappeared within two weeks—without diuretics. He was up and about, without complaints, until discharged two weeks later, when he weighed 88 pounds. We never could explain the edema.

Although no complete metabolic studies could be done, it appears that he was well compensated. There were no critical electrolytic or chemical deficiencies. One must assume that the remaining bowel of duodenum and jejunum measured at least 3½ feet, even though the surgical estimate was only 14 inches. The length of the small bowel[9] varies between 18 and 30 feet, depending on the height of the individual[10]. This man measured 5 feet, 2 inches, so his small bowel probably measured some 23 feet prior to surgery. Measurement of the bowel after removal from the body can be only poorly correlated with measurement *in vivo* because of the difference in muscle tone, blood, and lymph volumes and other properties associated with living gut. Measurement of the bowel radiologically approximates *in vivo* measurement.

Most of the patients reported with detailed metabolic studies possessed two to three feet of residual small bowel. In these patients, the carbohydrates were normally utilized, protein was 75 per cent absorbed[6], and fats absorbed poorly[7] with at least 45 per cent being lost in the stools[11]. The marked loss of calcium, when a large amount of fat is included in the diet, is responsible for the symptoms of tetany often manifest in these patients. The relative importance of proximal[12] versus distal[13] small bowel function in digestion and absorption is still under investigation[14], but it appears that the integrity of the proximal jejunum is of greater nutritional significance than the ileum. A subtotal gastrectomy deprived this patient of the time factor normally utilized for a thorough mixing of food with salivary enzymes and mucus, and gastric digestive enzymes as well as complex mucopolysaccharides and hematologic substrates.

Despite the profound loss of the absorption and metabolic capacity of the small bowel and the morphologic and the physiologic alterations that follow subtotal gastrectomy, this patient has been able to maintain his health satisfactorily, although he has failed to gain weight. Other patients observed with massive resection following regional enteritis have had more critical chemical disturbances perhaps due to residual intrinsic disease. The usual sequelae following massive resection of the small intestine — malnutrition, diarrhea, anemia, and edema — were present in this patient, but the radiologic observations associated with massive resection — namely dilatation, elongation, and hypertrophy of the remaining bowel — were minimal or absent because of time factors[8]. Perhaps the only compensatory feature noted was dilatation of the large bowel.



FIGURE I

The mucosal pattern of the small bowel is outlined vividly. The length is estimated as 3.5 feet beginning at the proximal duodenum. There are no significant dilatations.

†This was Viokase®, a tradename of the VioBin Corporation of Monticello, Illinois. It consists essentially of whole pancreas (Pancreatin NF) and is supplied in 5 grain tablets.

Summary

Massive resection of the small bowel with a residual segment of 3.5 feet of duodenum and jejunum in a patient who previously had suffered a two-thirds subtotal gastrectomy was compatible with adequate nutrition as evidenced by clinical and laboratory data.

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405 State St. (Dr. Friedman)

New Jersey's Brain Drain

New Jersey is exiling more youths of college age than any other state in the nation and is paying a high price for it in lost brainpower, the New Jersey Education Association charged last month. Thus, 56,852 New Jersey undergraduates are now attending colleges in other states. In return, New Jersey colleges received only 10,602 out-of-staters.

This means that we are sending away 46,250 more undergraduates than we receive from the rest of the nation. In every corner of the nation, college "out-migrants" from New Jersey outnumbered the residents of that state being educated in New Jersey.

"A large percentage of the young people who go to other states for their college educations never return to live in the home state," says Dr. Frederick L. Hipp, NJEA's executive secretary. "New Jersey is experiencing the greatest loss in the nation of the most valuable of all resources—intelligent, educated, young people."

Most states by contrast (33 of the 50) actually receive more college undergraduates than they send away.

Among undergraduates in New Jersey's public colleges, 16 states had no representation. These same 16 states, though, were educating 1,373 New Jerseyans in their own public colleges

Michigan last year warned it plans to cut quotas of residents from states like New Jersey which make little effort to expand public colleges to meet demand. Michigan had 1,176 New Jersey undergraduates in its public and private colleges; New Jersey colleges counted only 62 Michigan residents. Counting public colleges only, the spread was 665 to 3.

New Jersey residents are not necessarily going to out-of-state colleges by choice. There just isn't room in New Jersey schools. The public colleges are turning away honor high school graduates.

STATE ACTIVITIES

September 20, 1964

A regular meeting of the Board of Trustees was held on September 20, 1964, at the Executive Offices. For the information of the membership, detailed minutes are on file with the secretary of each county society. A summary of the significant actions follows:

Mental Health Meeting . . . Authorized Dr. Robert S. Garber of Belle Mead—Chairman of the Society's Special Committee on Mental Health—to represent MSNJ at the Congress on Mental Illness and Health held in Chicago next month.

Medical Advisory Panel . . . Recommended the following to the State Division of Motor Vehicles, in compliance with their request for members to serve on the Advisory Panel on Epileptic and Convulsive Disorders:

Ira S. Ross, M.D., South Orange
Eugene Revitch, M.D., Plainfield
Francis A. Wood, M.D., Newark
Erich H. W. Simon, M.D., Trenton

Recommended that, because the present panel is unable to handle the rather heavy case load, an additional panel be appointed and that the Division make arrangements to compensate panel members for their work.

Mental Health Programs . . . Appointed Dr. Joseph R. Jehl of Clifton—MSNJ's First Vice-President—as Executive Secretary of the Task Force on Medical Practice and Hospitals and as a member of the State Mental Health Planning Study Group—under the sponsorship of the Division of Mental Health and Hospitals of the New Jersey State Department of Institutions and Agencies.

Nursing Institute . . . Designated Dr. William H. Hahn of Newark and Dr. Solomon Weintraub of Trenton to represent the Society at an Institute on Legal Aspects of Nursing, to be held in Newark on December 1 and December 8, under the sponsorship of the State Nurses' Association.

College Bond Issue . . . Endorsed the college bond issue, scheduled to appear on the November ballot, recommending new construction at Rutgers, the 6 state colleges, and Newark College of Engineering to accommodate an additional 10,645 qualified students.

Identification of Patient Needs . . . Submitted to the American Medical Association the names of Dr. John J. Bedrick of Bayonne, President-Elect, and Dr. William P. Mulford of Burlington to represent the Society at the second conference on Identification of Patient Needs, sponsored jointly by the AMA and the American Nursing Association.

Congress on Stroke . . . Designated Dr. Robert A. Kuhn of Morristown to represent MSNJ at the AMA Congress on Stroke in Chicago on October 29-31.

Area-Wide Health Facilities Planning . . . Requested Dr. Louis S. Wegryn to serve as the Society's representative at the AMA's Conference on Area-Wide Health Facilities Planning, to be held immediately preceding the AMA Clinical Meeting in Florida.

Nursing Education and Recruitment . . . Concurred in the opinion of the Permanent Joint Committee on Nursing Education and Recruitment to arrange a meeting with the Governor and present its conclusions with supporting data.

1965 Annual Meeting . . . Approved the following recommendations of the Annual Meeting Committee:

1. That the intervening day between the second and third sessions of the House of Delegates be continued for 1965
2. That the 1965 Annual Meeting schedule be the same as 1964
3. That delegates be seated in the 1965 House in county groups, with identifying signs
4. That the scientific sessions not be recorded at the expense of the Society; agreed that program officers desiring so may have sessions recorded at their own expense
5. That special scientific programs be scheduled for Tuesday, May 18, 1965, concurrent with the third and final session of the House of Delegates.

Disapproved the recommendation of the committee that the addresses of the President and Incoming President be scheduled for the second session of the House after the close of the election.

Seton Hall . . . Noted a communication from Governor Hughes in which he asked the Society's support of the recommendation that the State take over the Seton Hall Medical and Dental School as soon as possible; and suggest-

ing that MSNJ communicate with the legislative leaders urging support of this proposal.

Appointed an *ad hoc* Committee on Development of Medical Schools in New Jersey, "to keep an eye on medical education in New Jersey and to give constructive leadership" as follows:

John J. Bedrick, M.D., Chairman, Bayonne
Joseph R. Jehl, M.D., Clifton
Joseph P. Donnelly, M.D., Jersey City
Jerome G. Kaufman, M.D., Maplewood
Fred A. Mettler, M.D., Blairstown

Audit Review Committee. Acted upon the recommendations of the Audit Review Committee, as follows:

1. Reaffirmed its 1959 action authorizing that the balance in the Annual Meeting reserve not exceed $10,000; and that each year, any excess reserve after payment of expenses be transferred to the Medical Student Loan Fund.
2. Raised the base level of the general surplus from $100,000 to $150,000.
3. Appointed a special committee to study the recommendations of the Audit Committee that the fiscal year of the Society be changed to the calendar year:
   Chairman, Committee on Finance and Budget (Dr. Ware)
   Treasurer (Dr. Featherston)
   Chairman, Audit Review Committee (Dr. Hughes)
   Chairman, Committee on Revision of Constitution and Bylaws (Dr. Albright)
   Auditor (Representatives of J. S. Teunon & Co.)
   Executive Director (and other office personnel as required) Ex-Officio
4. Increased membership of the Audit Committee from three to five members.

Medical Student Loan Fund . . . Approved the report and recommendation of the committee, as follows:

1. That there be a regulation concerning the repayment of a loan when the student drops out of medical school; and that this be part of the promissory note.
2. That there be a regulation requiring *compulsory internship in New Jersey* for all students who obtain loans; that there be repayment of the full loan immediately following graduation if the borrower does not intern in New Jersey, and that this also be made part of the promissory note.
   Legal Counsel, Mr. Backes, was requested to draw up the proper amendments to the regulations and the promissory note. Mr. Backes suggests the following revisions:
   1. Modify the existing regulations dated 9/15/63 as follows:
      Delete the "note" at the bottom of the page which reads:
      This Fund was made available to encourage internship and practice in New Jersey. It is suggested that you consider your request for a loan in this light and, if granted, accept the loan on these terms.
      Substitute therefore:
      7. This Fund was made available to encourage medical education as well as internship and medical practice in New Jersey. It is suggested that you consider your application in this light and if approved, accept the loan on these terms. In the event a borrower terminates his medical school education, voluntarily or involuntarily, or interns, or practices outside of the State of New Jersey, his obligation to repay the funds borrowed will be immediately accelerated.
   2. Add to the existing promissory note the following paragraph:
      Payment hereof shall be accelerated by termination of medical school education, the acceptance of internship or the commencement of medical practice beyond the limits of the State of New Jersey so as to make the entire amount, or the unpaid balance, of this note immediately due and payable with interest of 6% from the date of such termination, acceptance or commencement.

Associate Assessment . . . Approved the recommendation of the Treasurer that the 2/3 assessment for associate members—adopted by the 1964 House of Delegates—not be effective until January 1, 1965, when the regular 1965 *per capita* assessment becomes effective.

Public Relations . . . Approved the following continuing projects for 1964-65—under the sponsorship of the Council on Public Relations:

1. Publication and distribution of:
   a. *Junior Health Hints* to schools and public libraries
   b. *Health Hints* to the press, house organs, and other media, over the signature of "Michael S. Newjohn, M.D."
   c. *Membership News Letter,* including the annual compilation of a bound, indexed set to component societies
   d. *Periodic Newsletter* to cooperating agencies and individuals
2. Preparation and publication of special news releases and publicity as required from time to time in furtherance of the Society's business and interests, including:
   a. 1965 Eye Health Screening Program
   b. 1965 Annual Meeting
3. Responsibility for the bestowal of the Golden Merit Award
4. Responsibility for the press room at the annual meeting
5. Continuance of consultative service in support of the public relations activities of component societies
6. Encouragement of indoctrination program under the sponsorship of the component societies

Emergency Medical Coverage . . . Approved the recommendation of the Council on Public Relations that a subcommittee of the Council be appointed to study at the earliest possible time the county reports of recommendations in conjunction with emergency coverage, suggesting procedures that may be adopted or modified; agreed that emergency medical coverage is a responsibility of the community as well as that of the doctor.

AMA Communications Program . . . Approved the recommendation of the Council on Public Relations that the Board of Trustees send a letter to the AMA Board of Trustees voicing strong opposition to the establishment of any type of "wire communications system between the AMA headquarters in Chicago and offices of state medical associations."

The council strongly suggests that the AMA concentrate on elimination of procedures which seem to involve duplication of effort and expense.

Nationwide Education Program . . . Approved the action and recommendations of the Council on Public Relations, as follows:

The Council, in lively and extended discussion, examined the whole project and noted the following points:

1. The program was adopted by the AMA Board of Trustees for implementation in New Jersey by MSNJ and its components without consultation with MSNJ's officers or delegates or without request for the Society's opinion or reaction.
2. It involves complex and detailed cooperation with component societies for its effectuation, and in so doing imposes heavily upon the time of officers and staff at both state and county levels.
3. It is ill-timed because admittedly the Congress will have disposed of Medicare—at least for this legislative year—before the program of advertising is presented.
4. State and/or county societies are called upon to sign advertisements as their own, thus tacitly assuming responsibility for their content and form and making themselves obligated to deal with any and all controversial or other responses.
5. The budget assigned to New Jersey impressed the council members as inadequate to meet the costs of placing advertisements in all New Jersey's daily and weekly newspapers (total 222). In their view, selective discrimination—either by state or county societies—favoring some and rejecting other papers, would produce bad press relations.
6. The council viewed the expenditure of large sums of AMA money in this type of advertising program as inviting the public impression that the physicians of the country have present advantages which they seek to retain, even at the cost of millions of dollars.

In the light of the foregoing, the Council voted to *recommend* to the Board of Trustees that MSNJ decline to participate in this program.

Speech Training Sessions . . . Concurred in the action of the Council on Public Relations in approving on a pilot basis regional meetings for the presentation of a speech training service —offered by Smith Kline & French—designed to help professional organizations in the health field to form public speaking and public relations programs.

Medicare . . . Received and noted the following report of the Medicare Committee:

As authorized by the Board of Trustees, at its meeting on July 19, 1964, the following amendment to the Medicare Contract has been negotiated, effective August 1, 1964:

Anesthesia—Relationship to Surgical Procedure—(except for obstetrical deliveries and tonsillectomies) 20% of Surgical Procedure or $15.00 whichever is greater.

The fee of $20.00 for obstetrical anesthesia involving delivery by manipulation and the fee of $20.00 for tonsillectomy anesthesia either local or general, remains unchanged.

1966 Annual Meeting . . . Designated three trustees—Dr. Jerome G. Kaufman, Dr. John J. Bedrick, and Dr. Joseph R. Jehl—to augment the Annual Meeting Committee for the 1966 Annual Meeting—at which time the Society will celebrate its bicentennial; requested that the augmented committee formulate plans and arrangements for the meeting as soon as possible.

AMA Clinical Meeting . . . Authorized the following to attend the Clinical Meeting in Miami Beach with expenses paid: President, President-Elect, Executive Director, authorized delegates, and two alternate delegates (Dr. Jehl and Dr. Kustrup).

Nominations

1. Submitted to the Commissioner of Education the name of Dr. Robert E. Jennings, Chairman of the Society's Committee on Child Health, for appointment to the Advisory Council on the Emotionally Disturbed Child—to succeed Dr. McCall of Newton.

2. Submitted to the Governor the name of Dr. Kimler to succeed himself as a member of the Advisory Council on the Chronic Sick.

3. Submitted to the Governor the name of Dr. John F. Kustrup of Trenton for appointment to the Public Health Council of the State Department of Health—to succeed Dr. Blaisdell of Asbury Park.

Health Careers Service . . . Named Dr. Wegryn of Elizabeth as the Society's representative to the fall meeting of Statewide Partners in Health Careers in East Brunswick on October 19.

Perinatal Mortality . . . Approved the request of the Academy of Medicine of New Jersey to co-sponsor with our State Health Department a seminar on perinatal mortality broken down into four meetings throughout the state.

ANNOUNCEMENTS

Office Psychiatry for the Non-Psychiatrist

A course in psychiatry for the non-psychiatrist is now available, through Seton Hall in Jersey City, on Thursdays at 10 a.m. The first class will be held on January 7, 1965. The curriculum covers eight sessions on consecutive Thursday mornings. Tuition is free for members of The Medical Society of New Jersey. For details, write to Chairman of Psychiatry, Seton Hall College of Medicine, 24 Baldwin Avenue, Jersey City 07304.

Cancer of the Oral Regions

The New Jersey Dental Society, in cooperation with the State Health Department, The Medical Society of New Jersey, and Fairleigh Dickinson University, announces a graduate course in "Cancer of the Oral Regions" (on five consecutive Wednesdays) starting on March 17. Classes will be from 9:00 a.m. to 5:00 p.m. at Fairleigh Dickinson School of Dentistry. The course stresses early detection of oral cancer and related neoplastic lesions of the head and neck.

A discussion of the problems of differential diagnosis of jaw lesions is planned. Odontogenic tumors, salivary gland tumors, neoplastic lesions of the larynx, pharynx, paranasal sinuses, and neck will be covered. A one-day symposium on the present-day management of head and neck cancer will conclude the course.

Enrollment is limited. No registration or tuition fees are charged. Attendance is open to New Jersey physicians and dentists. The course is supported by the Public Health Service.

For information and registration, write to:

Ernest Baden, D.D.S., M.D.
Department of Pathology
Fairleigh Dickinson School of Dentistry
1000 River Road, Teaneck, New Jersey

Industrial Medicine Course

Announcement is made of a one-week, full-time course in industrial medicine, starting March 8, 1965, under the auspices of Columbia University. For details, write to Public Health Education, Room 305, at 21 Audubon Avenue, New York, N. Y. 10032.

Colloquium in Ophthalmology

A 3-day intensive colloquium on modern ophthalmology is announced for Philadelphia February 18-20. For program, write to Dr. Joseph W. Hallett, Wills Eye Hospital, 1601 Spring Garden Street, Philadelphia, Penna. 19130.

New New Jersey Pathology Diplomates

Announcement has been made that the following New Jersey practitioners have been recently certified by the American Board of Pathology:

Dr. Stuart M. Anderson, Hackensack
Dr. Donald F. Shields, Hackensack
Dr. William D. Sharpe, Jersey City
Dr. Gabriel Yelin, Newark
Dr. Blanka Sender, Paterson
Dr. Walter G. Sawchak, Trenton
Dr. Henry E. Seidel, Somers Point

New Jersey Ileostomy Clubs

Many of our readers do not know of the remarkable work done by organizations of patients who have had ileostomies. They have committees of ileostomied patients who visit with those about to have the operation—and offer help, comfort and, above all, assurance. They assist patients in adjustment to the defect. They give information on appliances, adhesives, personal adjustment problems, employment, pensions, insurance, and disability. For more information on these clubs, write to Mr. Robert W. Draper, 79 Easton Avenue, New Brunswick, N. J.

OBITUARY

Dr. Joseph I. Berlin

Filling a prescription by Dr. Berlin, the pharmacist mused: "This doctor must be a young practitioner, just starting out. This is a new drug." At the time, Dr. Berlin was in his 70s. He was born in New York in 1883, earned his M.D. at Loyola in 1911, and then established himself in Jersey City. At Greenville Hospital, he served for several years as president of the medical staff and for a quarter-of-a-century, was chief of the ear-nose-throat clinic there. He was an FACS and taught ophthalmology and otology at New York's Graduate Hospital. Dr. Berlin was a diplomate in otolaryngology.

Dr. Saul W. Chester

One of our state's pioneer allergists, Dr. Saul W. Chester, died on Sept. 12, 1964. Dr. Chester received his M.D. degree at Tulane in 1921. After interning at the Charity Hospital in New Orleans, he came to Paterson for a residency at the St. Joseph Hospital, and remained in Passaic County ever since. He founded both the blood bank and the allergy clinic at St. Joseph. Dr. Chester was also affiliated with the Lebanon Hospital and the French Hospital in New York. He was active in affairs of the American College of Allergists and the American Academy of Allergy.

Dr. Chester was born in Brooklyn in 1896. In 1917, at the age of 21, he enlisted in the Army of the United States, entering medical school on being mustered out the following year.

Dr. Robert M. Grier

More than 40 years of service to the people of South Jersey ended on August 29, 1964 with the death that day of Dr. Robert M. Grier, at the age of 67. Dr. Grier was a Jefferson graduate—class of 1920. He was a general practitioner of the old school who threw himself into civic and community activities without stint. Thus, he was a police surgeon, an American Legion Officer, a school physician, a public health officer, a president of the local Kiwanis, a medical member of the draft board, and had staff affiliations with both the Atlantic City Hospital and the Shore Memorial. Dr. Grier practiced in Pleasantville, but his civic and professional activities took him to also every community in Atlantic and Camden Counties. Born in Pennsylvania in 1897, he came to New Jersey to intern at the Atlantic City Hospital, and became so attached to New Jersey that he remained to serve its people ever since.

Dr. Clarence J. M. Hofer

In December 1924, the freshman class at Jefferson Medical College met to select a president. They had known each other only 2½ months. But Clarence J. M. Hofer had already exhibited enough leadership to be chosen as class president. A Rutgers graduate, Clarence Hofer had long before, and since that date, exhibited those leadership qualities. Born in Philadelphia in 1902, he came to Metuchen in childhood. In 1928 he received his M.D. at Jefferson. He was active in the Naval Reserve and in a wide spectrum of civic affairs. He had been school physician, police surgeon, health officer, school board member, and a Red Cross leader. He had done graduate work in pediatrics and internal medicine, but was proud to be called a general practitioner and a family doctor. On August 28, 1964, he quietly passed away after a long illness.

Dr. Leonard E. Kremer

At the untimely age of 47, Dr. Leonard Earl Kremer died of a coronary attack while at the wheel of his car on September 24, 1964. Born in New York in 1916, he received his M.D. at Bellevue in 1941. After interning at St. Joseph's Hospital in Paterson, he served with our Armed Forces overseas from 1942 to 1945. He was a

prisoner of war in Germany for two of those years, until liberated by General Patton's army. Dr. Kremer was certified in orthopedics and was head of that department at Barnert Hospital in Paterson. He was also affiliated with the New Jersey Orthopedic Hospital and the Hospital for Joint Diseases in New York.

Dr. Philip Kresch

One of our state's pioneer radiologists died on October 18, 1964. He was Dr. Philip Kresch, a lifelong resident of Bayonne, where he was born in 1893. He received his M.D. at Bellevue in 1916. His internship was at Harlem Hospital and then, in 1917, he entered the medical corps of the Army of the United States. After two years of overseas service, he returned to his native city. He did graduate work in radiology and became a Board diplomate in that specialty. He was the senior consulting radiologist for the Regional Office of the Veterans Administration in New Jersey.

Dr. Charles E. Sharp

A past-president of the Cumberland County Medical Society, Dr. Charles E. Sharp of Port Norris ended a long and useful life on October 23, 1964 at the age of 72. He received his M.D. at Jefferson in 1914. Dr. Sharp interned at the Cooper Hospital in Camden. He was on the active staffs of both the Millville and Bridgeton Hospitals, and had several tours of duty as chief of staff at the latter hospital. He was president of his county medical society in 1919 and 1920. Dr. Sharp was active in civic and business affairs in southern New Jersey. Only a few months ago, he was the laureate of one of our Society's Golden Merit Awards.

Dr. James B. Shannon

New Jersey lost one of its best-known and most distinguished otolaryngologists with the death, on October 20, 1964 of Dr. James B. Shannon. Born in Tennessee in 1895, he received his M.D. at Vanderbilt in 1921. After interning in Nashville, he came to Bellevue for a three-year residency in his chosen specialty. He became an instructor at Columbia University's medical school, and later was Clinical Professor of Otolaryngology at New York University. A special medical library was named for him at Bellevue in 1959. He practiced in Montclair, and was attending or consulting otolaryngologist at many hospitals in northern New Jersey. He was a board diplomate in otolaryngology and an FACS. He served a term as president of the Clinical Society of the Oranges and later, as president of the Associated Physicians of Montclair and vicinity.

Dr. John M. Wetherhold

At the untimely age of 58, Dr. John M. Wetherhold, medical director of the local DuPont works, died on October 26, 1964. He received his M.D. at the University of Pennsylvania in 1931. He was a consultant in preventive and industrial medicine, and a diplomate of the American Board of Preventive Medicine. Dr. Wetherhold was active in civic affairs and was an elder of the Union Presbyterian Church. Dr. Wetherhold was attending physician in Industrial Medicine at the Salem County Memorial Hospital.

Dr. Alfred Widetsky

A leading Passaic County obstetrician and gynecologist, Dr. Alfred Widetsky died on October 19, 1964 at the age of 63. In 1927 he was graduated from the medical school of the Iowa State University. He came to Paterson to intern at the General Hospital there, and remained in this area for the rest of his life. For a quarter of a century, he was surgeon to the Bergen County Police Department. For many years, he was school physician to the East Paterson Board of Education. He was on the active staff of the Paterson General Hospital.

BOOK REVIEWS

Internal Medicine, Volume II (Infectious Diseases). Prepared under direction of The Surgeon General of U. S. Army. Washington, D. C., 1963, Department of the Army. Pp. 649. Illustrated. ($6.95)

This text, one of twenty prepared by The Historical Unit, U. S. Army Medical Service, concerns itself with the combat record of the Medical Department of the Army against various infectious diseases during World War II. The list of contributors is a valuable "Who's Who" of medicine in the U. S. These contributors were on the spot during World War II, and write from proved previous knowledge and wide experience.

Dealt with are numerous diseases which were well known to medicine for which specific therapies were not known. Many were "old hat", but their magnitude and epidemiology made them potent adversaries to the medical officer. In the list of diseases are some new ones which never, before World War II, had a name or identity.

This is an interesting book and a scholarly presentation. It reads easily; and for those who were in the Service, it evokes memories. It is commended to those who want a commanding knowledge of the many infectious diseases described. I consider the book a valuable addition to any medical library.

David Eckstein, M.D.

Prevention of Hospitalization. Milton Greenblatt, M.D. and others. New York, 1963, Grune and Stratton. Pp. 182.

It is repeatedly said that if we had enough mental hygiene facilities, we would have fewer hospital patients. But this is the first time anyone has set about finding out if this is really true. The Community Extension Service (of the Massachusetts Mental Health Center) worked with a waiting list of patients who had been referred to state hospitals. This new project succeeded in keeping half of the subjects out of the hospital. Tranquilizers were prescribed for acute symptoms; individual psychotherapy, social case work, counselling, manipulation of the environment and—above all—an expectation that the patient would not need hospitalization—were the chief instruments. The staff often made house calls, an almost unheard of amenity in modern dynamic psychiatry. The Service accepted no fees. If they had, many of the families would have had to insist on hospitalization because they could not afford fees.

Some 90 per cent of the patients were under the age of 57; and 44 per cent of them were neurotic or psychosomatic, or had personality disorders rather than psychoses. Thus, at least half of the patients should not have been sent to long-term hospitals anyway. Still, all of them had been referred by their family doctors or private psychiatrists for admission to State Hospitals; and half were spared that experience because of the intensive and effective program provided by this pioneer service.

Henry A. Davidson, M.D.

Margin of Safety. By John Rowan Wilson, M.D. Garden City, 1963, New York. Pp. 258. Illustrated. ($4.95)

Margin of Safety reviews the birth and history of the various poliomyelitis vaccines. The author outlines the scientific, social, political, and emotional forces which are brought into action during such a mammoth undertaking as this.

Dr. Rowan takes his title, *Margin of Safety*, from the laboratory. He questions precautions used by scientists during their experimentation with these organisms. Basic ethical and moral issues are superimposed in these margins as concerns examples of "volunteers" (mental defectives) used in one of the experiments and the children who have died or have become scarred due to the problems associated with viral diseases and the testing procedures available.

Salk, Sabin, Cox, and Koprowski are dissected intellectually and emotionally as they attempt to push toward the eradication of poliomyelitis. The author very adeptly compares these four men in their power struggle. He discreetly ex-

amines their abilities and liabilities. Salk is depicted as the young, energetic American; Cox, as the retiring mid-Westerner; Sabin, as the industrious, close-mouthed European; and Koprowski, as the intellectual golden-tongued Cicero with a continental flare.

Looming in the distance behind these men are the institutions which financially support them. Without the assistance of the National Foundation or the pharmaceutical firms, research into this would be rather limited. The author also considers the problem of scientific forces not operating for the common good but only for the institution whether it be in terms of money, power, or prestige. He examines this ethical problem in conjunction with government competitive research and asks whether government or business will direct research. He interestingly weighs the pros and cons of the dead and live viral vaccine.

The reader will gain insight into the problems and pitfalls which face the researcher in his never ending struggle. The author's style is direct and uninterrupted. He keeps scientific jargon to a minimum. William H. Nace, R.N.

Psychiatry and Psychology. By H. L. Silverman, D.Sc., Ph.D. Springfield, 1963, C. C. Thomas. Pp. 70. ($4.50)

Between psychiatrists and psychologists there is, at present, an uneasy truce. The two chief issues are the psychologists' insistence on their right to do psychotherapy without medical supervision; and their feeling that psychiatry (so far as its unique "mental" aspect is concerned) is a daughter of psychology, which should be recognized as its mother science. The author suggests that psychology has brought to psychiatry a tradition of objective measurement, methodology, and logic which clinical medicine causes some of us medical people to forget. To quiet the troubled waters, Dr. Silverman proposes that psychiatrists accept teaching from psychologists (just as psychologists now welcome teaching by psychiatrists) and that there eventually be a program for training nonmedical psychologists to become "doctors of psychological medicine."

In his introduction, Dr. M. M. Stern (a member of The Medical Society of New Jersey) sounds pessimistic about any early reapproachment. He doubts if psychologists can give any ground at all. "Any concession by psychologists," he concludes gloomily, "will deflect them from their goal of establishing themselves as full-fledged psychotherapists."

The text is, of course, not an impartial survey. It is special pleading on behalf of "giving psychologists admission into the full field of mental hygiene." If its partisan approach is understood, the book can be read as a vigorous brief for the psychologists' position.

Abraham Leff, M.D.

Bilharziasis. Edited by G. E. W. Wolstenholme, M.D. and Maeve O'Connor, B.A. Boston, 1963, Little, Brown and Company. Pp. 433. Illustrated. ($11.50)

Ciba Foundation continues the publication of their symposia (on the centenary of the death of Dr. T. M. Bilharz) with this volume on the modern aspects of research in bilharziasis and its control. A discussion of epidemiology, ecology of intermediate hosts (snails), and the parasites and their intermediate hosts (mammals) emphasizes the world-wide character of the infestation, from South America through the Middle East to the Far East. (In Egypt, for example, 25 per cent of hospital autopsies reveal manifestations of the disease.) The physiology of the schistosomes, clinical and pathologic aspects of bilharziasis, current immunologic studies and chemo-therapy are considered in great detail.

Bilharzial lesions are of two types: (a) the chemo-allergic tissue response to the deposition of ova, and (b) the reaction induced by the death of the worms following therapy. Inflammation of portal venules in the liver and pulmonary arterioles with granulomatous stenosis following repeated embolization is well-known. Less well-known is bladder neck obstruction resulting in bilateral hydronephrosis and renal destruction.

Infection of the urinary bladder is said to predispose to cancer of the bladder; and 19 per cent of all carcinomas in Egypt involves the urinary bladder. According to these authors, tryptophan metabolites are potent bladder carcinogens. However, these substances are also

elevated in carcinoid disease and sprue; and as far as I know there is no association between carcinoma of the bladder and these latter diseases.

Treatment with various schistosomicide agents includes the antimony compounds, muracils (lucanthone), and newer agents like parasaniline.

This volume is a valuable addition to the public health worker in the field and to the specific knowledge of parasitic diseases. In one of the final chapters, four lines of attack on this scourge of humanity are outlined: mass treatment of all individuals, education to minimize pollution of water with human excreta, environmental sanitation, and snail control to eliminate the vector.

Abraham I. Friedman, M.D.

Handbook of Pediatric Medical Emergencies. By Adolph G. DeSanctis, M.D. and Charles Varga, M.D. Mosby, 1963, St. Louis Ed. 3. Pp. 438. ($12.75)

As the title indicates, this is meant as a guide for how to handle pediatric medical emergencies. Actually, though, it deals with the acute and severe illnesses in infancy and childhood that urgently require immediate therapy. Because of this, much background material (research and practical) is discussed. This makes for a comprehensive handbook-guide. As an example, consider the chapter entitled "Metabolic Emergencies." Here is outlined and discussed every possible variation of fluid imbalance and electrolyte defect resulting from every possible metabolic disturbance. The author goes into history, clinical symptoms, physical examination, laboratory studies, and prevention of these disturbances giving general principles of treatment. One would wish, however, that the chapter was a little less involved and more easily understood. Many intricate tables and formula are offered.

The book follows an orderly pattern of detailing all the emergencies involved with each body system—such as cardiac, respiratory, genito-urinary, neurologic, and so on.

The revisions have kept pace with newer advances. In this third edition, two new chapters have been added which deal not only with the emergencies of the newborn but also those in the psychiatric realm. Included is a "do-it-yourself" chapter on pediatric procedures accompanied by excellent illustrations.

Of inestimable value is the table on dosage of drugs commonly used in emergencies. In general, this handbook blueprints "what to do until the pathologist arrives" and is a "must" for the pediatrician's bag.

Ralph N. Shapiro, M.D.

Review of Physiological Chemistry. By Harold A. Harper, Ph.D. Ed. 9. Los Altos, California, 1963, Lange Medical Publications. Pp. 437 ($6.00)

This volume marks the advent of paperback books in the chemical field. It is a concise summary of the subject, covering carbohydrate, fat, protein metabolism, nucleo-proteins, prophyrins, and enzymes.

The chapter dealing with the gastro-intestinal tract should be read by every practicing physician. Functions of the liver, kidney, and methods of testing for their adequacy are well presented. The discussion of the hormones is excellent. It concisely summarizes the physiology of aldersterone. The final chapter of general and physical chemistry could well serve as a concise review for the chemical neophyte in his freshman year at any college.

Especially commendable is the pictorial presentation of chemical formulae. The Krebs cycle of aerobic metabolism of carbohydrate and Embden-Meyerhof Pathway of anaerobic glycolysis is well illustrated by formulae. An excellent index accompanies the volume as well as a page and a half devoted to the presentation of an explanation for the alphabetical abbreviations widely utilized throughout the text. The text is composed of basic science lectures presented in connection with the graduate training of physicians, especially those preparing for board examinations. It will also be helpful to maintain the practicing physician's perspective in the bio-chemical discipline. The author is to be complimented for having successfully accomplished this task.

The book would have been more readible if larger type were available. The excellent presentation of the subjects would seem to merit this change. Thomas K. Rathmell, M.D.

Nursing Care of The Long-Term Patient. By Jeanne E. Blumberg, R. N. and Eleanore E. Drummond, R. N. New York, 1963, Springer Publishing Company. Pp. 134. ($2.75)

This concise paper bound book is written by two R. N.'s for nurses involved with long term care. Here, few specific methods and technics are described or taught. Emphasis is on attitudes that the nurse or attendant should develop.

Eight "key concepts" are handled in separate chapters. These are: (1) Physical Care (2) Emotional support (3) Observations (4) Treatment (5) Teaching (6) Economics (7) Complex correlations and (8) Counselling.

In each the authors endeavor to produce better patient care by enlarging the nurses' knowledge of all factors significant to the patient. This approach is not usually taught in medical books and certainly presents nursing care in its broadest scope.

While few doctors might feel interested in this, those in nursing homes and other areas of long term care would find it valuable to view the patient within his full setting, rather than just as a disease complex.

Except for the introduction, in which the authors use the now familiar and confusing "education jargon", the book reads easily.

Irving M. Levitas, M.D.

Surgery. By Richard Warren, M.D. Philadelphia, 1963, Saunders. Pp. 1397. Illustrated. ($19.50)

This first edition is a 1400 page text with 511 illustrations, edited by a Professor at the Harvard Medical School. The aim is to produce a book on surgery for students of medicine and surgery, to fill a vacuum which may not have seemed apparent to the host of weary doctors who consider too much is written already.

To the large group of doctors between the ages of 40 and 55 who were exposed to Holman's *Textbook of Surgery* as their original surgical text, this is a fitting continuation of the meticulous presentation of the details of surgical technic, and one which will always serve as a reference text for the surgeon after his formal training is finished.

The basic principles of surgery in all fields of teaching are presented in detail with generous charts, specimens and illustrations to thoroughly explore each and every topic presented. The 34 chapters into which the book is divided are a beautiful example of what a complete text can be, although bound in one volume. Each of the surgical specialties is thoroughly handled by a recognized expert in the field and the text cannot help but have immediate acceptance both by the student of medicine and the practitioner of surgery long after his formal training is complete. I feel that it will be enthusiastically accepted by the medical profession as a whole.

Daniel F. Featherston, M.D.

The Ovary. Edited by Hugh G. Grady, M.D. and David E. Smith, M.D. Baltimore, 1963, Williams and Wilkins. Pp. 287. Illustrated. ($13.50)

This is the third in the International Academy of Pathology series of Monographs in Pathology. Entitled "Pathology and Anatomy of the Ovary," it is a compendium of presentations offered at 1962 meeting of the Academy. This is a most complete reference book on the ovary. Starting with embryology, succeeding chapters are devoted to the ovary in infancy and childhood; histology; synthesis of ovarian hormones; ovarian hormones and reproductive mechanisms; an especially fine chapter on pathogenesis of sexual anomolies, with a very complete presentation of what is known of chromosomal aberrations; normal and abnormal ovulation; and chapters on androgenic lesions, estrogenic lesions, and non-functioning neoplasms. The final chapter, an interesting sidelight, discusses the ovaries in animals.

Each chapter is a complete presentation of the subject in great detail, beautifully illustrated, by an acknowledged authority. Presupposing a better than basic knowledge of the subject, it is nevertheless easy to read (one chapter at a time) and well worth digesting. It belongs in every hospital as well as general medical library—for reading, for reference, and for help in understanding the usual cases as well as the unusual. Many endocrinologists will also want it in their personal medical libraries.

Zelda I. Marks, M.D.

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ABSTRACTS

ON TUBERCULOSIS AND OTHER RESPIRATORY DISEASES. ISSUED BY THE NATIONAL TUBERCULOSIS ASSOCIATION

DECEMBER, 1964 • VOL. XXXVII, No. 10

CURRENT THERAPY IN CYSTIC FIBROSIS

Once a fatal disease in young children, cystic fibrosis is now being treated with encouraging results. Therapy is directed at both the digestive and pulmonary aspects of the disease. Early diagnosis and intensive treatment can enable the patient to reach adulthood.

Cystic fibrosis once was almost 100 per cent fatal in early childhood. Improved diagnosis and treatment have changed the prognosis. The treatment program developed in the past six years at the Cystic Fibrosis Research, Teaching and Care Center of the Babies and Children's Division, University Hospitals of Cleveland, is reported here.

Cystic fibrosis is transmitted as a mendelian recessive trait and is one of the more common hereditary diseases, occurring in about one of every 2,000 live births.

The basic defect in the disease is unknown. Current evidence indicates that it is a disease of the exocrine glands. The mucous glands of the respiratory system and gastrointestinal tract (including the pancreas and liver) produce an abnormally thick and viscid mucus. The sweat glands produce sweat with abnormally high salt content and the parotid glands secrete excessively.

One of the aids in diagnosis is the sweat test. This is a simple, accurate, and safe diagnostic procedure. By providing localized sweat stimulation, the pilocarpine iontophoresis technique or an intradermal injection of methacholine eliminates the necessity for the less reproducible and sometimes hazardous thermal sweating procedures. When a sweat test is negative in a suspicious case, the test should be repeated. Diagnosis should not be made on the sweat test alone.

Symptoms

The most prominent symptoms in cystic fibrosis arise from the digestive and pulmonary systems. The abnormally viscid secretions obstruct the pancreatic ducts and cause a deficiency of pancreatic digestive enzymes.

Pulmonary symptoms usually develop in early infancy. A chronic cough may be followed by recurrent episodes of pneumonia or by attacks of wheezing respiration which may be mistaken for bronchiolitis or asthma. The early pulmonary findings are not striking and might easily be dismissed. Mild signs of air trapping, a few rales, a slight increase in cough, and no weight gain must be looked for and treated vigorously to prevent the pulmonary lesion from progressing.

The primary pulmonary lesion is thought to be the accumulation of viscid secretions in the tracheobronchial tree. The mucus appears to impair the normal cleansing mechanism of the lung. The result is obstruction and stagnation of secretions and the development of secondary infection, which is usually due to *Staphylococcus aureus* and *Pseudomonas aeruginosa.*

If extensive damage occurs, bronchiectasis develops and abscess cavities form. These areas become reservoirs of infection. Reinfection, increased obstruction, and rapid progression of the pulmonary lesion are likely to occur.

Carl F. Doershuk, M.D. and Leroy W. Matthews, M.D. *GP,* February, 1964.

Treatment

Therapy is directed against the primary obstructive pulmonary lesion, the secondary pulmonary infection, and the pancreatic exocrine defect and nutritional deficiencies.

Among the treatment methods used at the Center are nebulization therapy. This is a means of depositing particulate water in the respiratory tract by use of a mist tent, and of depositing various medications through intermittent aerosol inhalations.

All patients with pulmonary involvement should inhale a dense mist during sleeping hours. In periods of active pulmonary disease, continuous day and night therapy is sometimes used. Mist-tent therapy is used nightly as a prophylactic measure even in patients with minimal evidence of pulmonary involvement.

Intermittent aerosol therapy permits the deposition of decongestant, antibiotic, bronchodilator, and mucolytic agents. Aerosol treatments are given three to four times a day.

The use of oxygen is discouraged, even in the hospital, unless it is specifically indicated. Coughing and expectoration are encouraged before and during aerosol treatments. Each treatment is followed by postural drainage and physical therapy to help remove secretions from the major bronchi of the lung. The patient must be carefully positioned so that the major bronchi of the affected lobes or segments of the lung will drain efficiently.

Initial hospitalization is recommended for a complete evaluation and to bring the pulmonary disease under control. The parents are instructed in the nature of the disease, the reasons for the therapeutic procedures, and the techniques utilized.

Prophylactic antibiotics are not used after hospital discharge because of the danger of drug resistance. They may be prescribed on follow up in accord with sensitivity studies.

Upper airway disease is appropriately treated. This helps prevent pulmonary disease.

Patients who have a pancreatic insufficiency should receive treatment for the digestive disturbance. Patients without chronic infection usually have a voracious appetite and thus gain despite their digestive defect. Frequent feedings for small infants are usually necessary. Control of the pulmonary infection is the most important factor in maintaining them in a good nutritional state.

Low-Fat Diet

Small infants should receive a low-fat, high-protein formula on demand and should be started on solid foods, including meat, when they are two months old. Older children are maintained on a high-protein diet.

Pancreatin is prescribed when a significant fat absorption defect is present, the dosage being based on the degree of the defect.

During warm weather, salt supplements help prevent heat prostration and shock.

All immunizations are carried out routinely. Influenza prophylaxis and the use of measles vaccine are especially important.

Emotional factors play a major role in any chronic disease—both for the patient and for the family. An interested, sympathetic physician can offer support for the patient and his family. Social service and psychiatric aid should be used freely.

The aim of treatment is to prevent progression if possible. Flare-ups do occur, even in well-treated children.

Since the initiation of the therapeutic program described in July, 1957, the annual mortality from cystic fibrosis among patients admitted to Babies and Children's Hospital has been less than 2 per cent annually.

This experience indicates that most patients who are diagnosed early and treated intensively should live into adulthood.

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1. Welch, C. E., Diverticula of the Alimentary Tract, in Conn, H. (editor): Current Therapy—1961, Philadelphia, W. B. Saunders Company, 1961, pp. 224-225.

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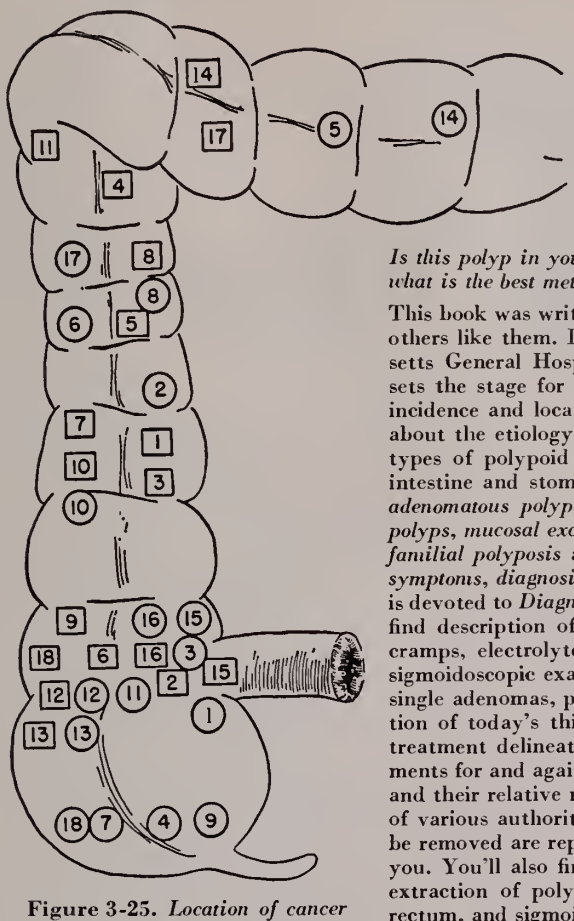


Figure 3-25. *Location of cancer and simple adenomas in resected cancers of the right colon. Squares locate cancers; circles, adenomas.*

Polypoid Lesions of the Gastrointestinal Tract

by Claude E. Welch, M.D.

Is this polyp in your patient benign or malignant? Should it be removed? If so, what is the best method for this particular lesion in this particular patient?

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1. Kunin, C. M., Dornbush, A. C. and Finland, M.: J. Clin. Invest. 38:1950, Nov., 1959.



This striking three-dimensional representation of Bowman's capsule illustrates the high glomerular filtration rate of Terramycin® (oxytetracycline). Unique in pharmacologic activity among the four tetracycline analogues, oxytetracycline has the highest 96-hour urinary recovery rate, the lowest protein binding, and the highest relative diffusion rate

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Information for Advertisers—RATES: $5.00 per insertion up to 25 words; 10 cents each additional word. Payable in advance. **WORD COUNT:** Count as one word all single words, two initials of a name, each abbreviation, isolated numbers, groups of numbers, hyphenated words. Count name and address as five words, telephone number as one word, and "Write Box No. 000, c/o THE JOURNAL" as six words. **COPY DEADLINE:** Fifteenth of preceding month.

199th ANNUAL MEETING
THE MEDICAL SOCIETY OF NEW JERSEY
May 15-19, 1965
Haddon Hall, Atlantic City

PROGRAM OUTLINE

Saturday, May 15, 1965

Morning	Registration Opens
Afternoon	House of Delegates—1st session
Evening	Nominating Committee

Sunday, May 16, 1965

All Day	Reference Committees
Afternoon	House of Delegates—2nd session (election)

Monday, May 17, 1965

All Day	Exhibits Open (9:00 a.m.-5:00 p.m.) Scientific Session: Obstetrics and Gynecology, Pediatrics Psychiatry and Neurology (Joint)
Morning	Scientific Sessions: Urology, Clinical Pathology (Joint) Allergy, Chest Diseases (Joint) Otolaryngology
Afternoon	Scientific Sessions: Medicine Rheumatism Anesthesia, Cardiovascular Diseases (Joint)
Evening	Annual Dinner

Tuesday, May 18, 1965

All Day	Exhibits Open (9:00 a.m.-5:00 p.m.) House of Delegates—3rd session
Morning	Special Scientific Sessions: Drug Addiction Perinatal Mortality
Afternoon	Special Scientific Sessions: Cancer Chemotherapy Community Mental Health Centers
Evening	Reception for Incoming President

Wednesday, May 19, 1965

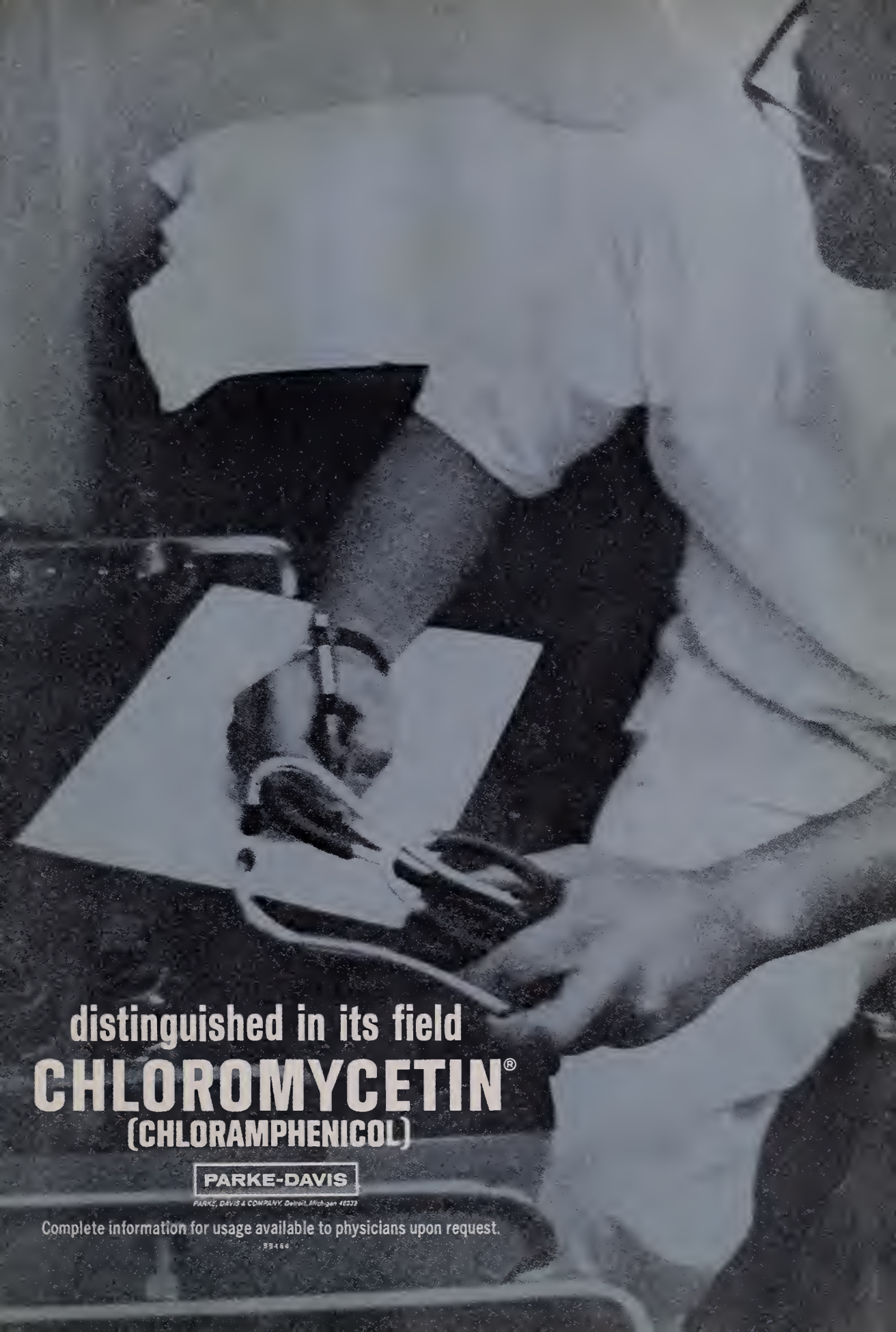
All Day	Exhibits Open (9:00 a.m.-3:00 p.m.) Scientific Session: General Practice, Gastroenterology and Proctology, Radiology, Surgery (Joint)
Morning	Scientific Sessions: Ophthalmology Dermatology Metabolism
Afternoon	Scientific Session: Orthopedic Surgery

1964-65 MEMBERSHIP DIRECTORY

We are pleased to announce the publication of the 1964-65 **Membership Directory** of The Medical Society of New Jersey. Barring any last minute delay, the directory will be ready for distribution the first week of December.

Each member in good standing will receive one copy of the directory free of charge, as a benefit of membership. For other than members, copies may be purchased at $7.50 each, postage pre-paid.

The directory offers several new features, including membership listing by counties and towns, addresses of county medical society offices, the license number of each physician, and a list of cities and towns within counties. In all, it will contain 428 pages.

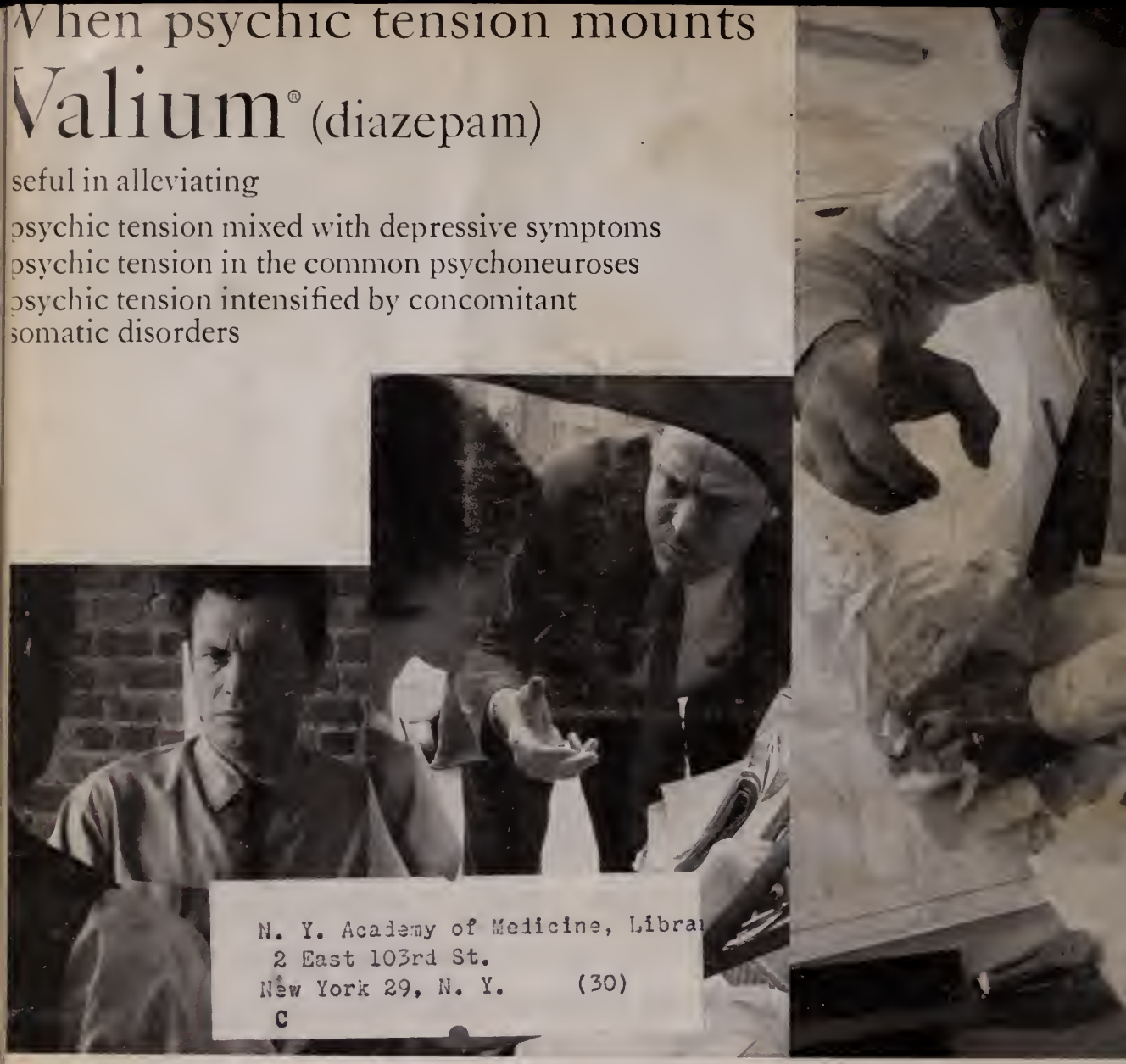

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ndications: Valium (diazepam) is of use in dealing with anxiety reac- ions stemming from stressful circumstances or whenever somatic com- plaints are concomitants of emotional factors. It is useful in psycho- neurotic states manifested by anxiety, tension, fear and fatigue.

Valium (diazepam) may also be useful in acute agitation due to alcohol withdrawal.

Valium (diazepam) may be of use to alleviate muscle spasm associated with cerebral palsy and athetosis.

Dosage and administration	*Usual daily dose*
Mild to moderate psychoneurotic reactions: Mani- ested by anxiety-tension alone or with depressive ymptomatology, agitation, restlessness, psycho- hysiological disturbances	2 mg to 5 mg, 2 or 3 times daily
evere psychoneurotic reactions: Where severe nxiety, fear, agitation, aggression or hostility ex- st alone or with depressive symptoms	5 mg to 10 mg, 3 or 4 times daily
lcoholism: As an aid in symptomatic relief of cute agitation, tremor, impending or acute de- irium tremens and hallucinosis	10 mg, 3 or 4 times during the first 24 hours; reducing to 5 mg, 3 or 4 times daily as needed
Muscle spasm associated with cerebral palsy or thetosis	2 mg to 10 mg, 3 or 4 times daily

Contraindications: Valium (diazepam) is contraindicated in infants, pa- ients with a history of convulsive disorders or patients with a history of glaucoma.

Warning: Valium (diazepam) is not of value in the treatment of psy- hotic patients, and for this reason should not be employed in lieu of ppropriate treatment.

Precautions: In elderly or debilitated patients, it is important to limit the dosage to the smallest effective amount to preclude the development of ataxia or oversedation (not more than 1 mg, 1 or 2 times daily initially, o be increased gradually as needed and tolerated). As is true of all CNS-acting drugs, until the correct maintenance dosage is established, patients receiving Valium (diazepam) should be advised against pos- sibly hazardous procedures requiring complete mental alertness or physical coordination. Driving an automobile during the period of Valium (diazepam) therapy is not recommended. In general, the concurrent administration of Valium (diazepam) and other psychotropic agents is not recommended. If such combination therapy is used, careful consideration should be given to the pharmacology of the agents to be employed with Valium (diazepam)—particularly with known compounds which may potentiate the action of Valium (diazepam), such as phenothiazines, barbiturates, MAO inhibitors and other antidepressants.

Since Valium (diazepam) has a central nervous system depressant effect, patients should be advised against the simultaneous ingestion of alcohol and other central nervous system depressant drugs during Valium (diazepam) therapy. Safe use of Valium (diazepam) during pregnancy has not been established. The usual precautions are indicated when Valium (diazepam) is used in the treatment of anxiety states where there is any evidence of impending depression; particularly the recognition that suicidal tendencies may be present and protective measures may be necessary. The usual precautions in treating patients with impaired renal or hepatic function should be observed.

Side effects: In clinical use, fatigue, drowsiness and ataxia have been reported; in most instances these are dose-related and may be avoided by proper dosage adjustment. Mild nausea and dizziness may occur on occasion. As with any new agent, when it is administered for protracted periods of time, periodic blood counts and liver function tests are advisable. Abrupt cessation after prolonged overdosage may, in some patients, produce withdrawal symptoms (e.g., convulsions, tremor, abdominal and muscle cramps, vomiting, sweating) similar to those seen with barbiturates, meprobamate and Librium® (chlordiazepoxide HCl). Changes in EEG patterns have been observed in patients during and after Valium (diazepam) treatment.

Paradoxical reactions, such as excitement, depression, stimulation, sleep disturbances, acute hyperexcited states and hallucinations have been reported. Other side effects noted have been blurred vision, diplopia, headache, incontinence, slurred speech, tremor and skin rash.

Valium (diazepam) is available as 5-mg and 2-mg tablets. For convenience and economy in prescribing, both strengths are supplied in bottles of 50.

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